Mental Health Services and Social Inclusion in Remote and Rural Areas of Scotland and Canada

A Qualitative Comparison

Daly, Clare Louise

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MENTAL HEALTH SERVICES AND SOCIAL INCLUSION IN REMOTE AND RURAL AREAS OF SCOTLAND AND CANADA: A QUALITATIVE COMPARISON

A thesis presented in fulfilment of the requirements for the degree of Doctor of Philosophy at the University of Aberdeen

CLARE DALY
BA (Hons) Social Science (First Class), University of the Highlands and Islands

2014
DECLARATION OF ORIGINALITY

I confirm that this doctoral thesis has been written entirely by myself and has not been submitted for any other degree.

I confirm that the work reported in the thesis was conducted by myself and not collaboratively.

All quotations have been distinguished by quotation marks and sources of information acknowledged.

........................................
Clare Daly
May 2014
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Finally, I would like to thank the service users who took part in this study and shared their experiences with me. This thesis would not have been possible without such contributions.

I dedicate this thesis to Rosie Mooney and Teresa O’Rourke, gone but never forgotten.
Mental health has become an increasingly important focus in the UK policy landscape because of its social and economic impact. However, most research to date has focused on living with mental health issues, or providing mental health services, in urban settings. There is limited understanding of the experiences of rural dwellers with mental health issues or the role of the voluntary sector in terms of its contribution to mental health service provision in rural areas.

Thus, this PhD explores the experiences of rural mental health service users and providers in Scotland and Canada, and also considers the contribution of mental health voluntary organisations in helping to overcome the challenges of social exclusion for service users, as identified in previous research.

Two theoretical lenses were used to frame the research questions. First, the concept of social inclusion provided a lens to analyse the processes by which service users achieve, or not, a sense of belonging and connection in society (Philo 2000). Second, Putnam’s (2000) theory of social capital provided a further analytical lens by which to explore the contribution of rural voluntary organisations. Social capital focuses on the features of populations such as social networks, trust and norms of reciprocity that shape the quality and quantity of social interactions (McKenzie & Harpham 2006).

The aims of the research were to:

- To explore the impact of rural life for mental health service users’ daily life and access of services
- To understand the contribution of rural mental health services to tackling social exclusion for service users

The five research questions used in this thesis were:

- What does it mean to experience mental health problems in remote and rural areas?
- What are the challenges that service providers face in remote and rural areas?
- What benefits are there for service users attending voluntary groups in remote and rural areas?
Do voluntary groups offer something that other rural mental health services do not?

Is social capital useful for understanding the benefits and role of mental health voluntary organisations in a rural setting?

These questions were addressed using qualitative methods. The experiences of service users attending voluntary organisations in Scotland and Canada were elicited through a focus group method. The views and perspectives of mental health professionals in both countries were also obtained through in-depth interviews.

The findings demonstrate that mental health stigma remains a considerable problem for rural service users in both countries but is more pronounced in Highland. Additionally, the close-knit nature of rural communities is challenging for service users in relation to maintaining anonymity and forging friendships. In terms of the policy of social inclusion, the findings demonstrate a ‘rhetoric-reality’ gap. A key finding from the study shows that the voluntary organisations facilitate and promote the process of recovery for members. Such findings are valuable given that there is an urgent need for qualitative work on recovery (Davidson et al., 2008). Using the analytical lens of social capital demonstrates the way in which service users can be connected to each other and their local communities by nurturing social ties. This element of the study is particularly important because it provides a detailed analysis of the relationship between mental health and social capital; demonstrating how positive mental health outcomes are achieved.

The study contributes to new knowledge on rural mental health. It highlights the significant role rurality plays in shaping the experiences of mental health service users and adds to the knowledge base on the rural voluntary sector, particularly in relation to the emergent recovery paradigm.
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CHAPTER 1

INTRODUCTION
1.1 Introduction to the thesis: rural mental health, social inclusion, recovery and social capital

Mental ill-health in a rural context represents a considerable challenge for governments globally due to its social and economic impact on populations. According to the World Health Organisation (WHO), mental health problems will affect one in four at some stage of life (WHO 2001) with depression predicted to be the biggest health burden on society by 2030 (Mathers & Loncar 2006). In the UK, mental health problems affect 16.7 million people (Medical Research Council 2010), and have been identified with contributing to and resulting from social determinants such as socio-economic deprivation and social isolation (Department of Health 2011a). In Scotland, some estimates suggest approximately 850,000 people are affected by mental health problems, with those who are classed as socially excluded to be at a higher risk (Audit Scotland 2009). Moreover, according to the Scottish Government (2011a), there has been a continuous rise in the number of prescriptions for antidepressant medication, from 1.16 million in 1992/93 to 4.3 million in 2009/10.

In terms of rurality, areas such as the Highlands of Scotland (the focus for the current thesis) remain under researched despite considerable issues with suicide. The current population of the Highlands stands at 222,370 (Highland Council 2013) and the prevalence of formally diagnosed depression and anxiety is 19,096 in Highland (8.6%). Highland has one of the highest suicide rates in Scotland (Highland Council 2009a). Prevalence of suicide in Highland from 2006 to 2010 was 172 (ScotPHO 2010), giving a rate of 0.08%. This compares to the Scottish averages of 4.3 million for depression and anxiety and 781 reported suicides in 2010 (Scottish Government 2011a), giving a suicide rate of 0.02%, and clearly demonstrates that treatment and support for people with mental health issues is a priority. According to the Highland Council (2009), between 40,000 and 50,000 adults within the Highland area will experience mental health problems at some point in their lives. In 2009 the total caseload of the twelve Highland Community Mental Health Teams was 2,300 with 25% of people with a schizophrenic illness and 40% with depression and anxiety. In a recent NHS Highland review it was noted that whilst the suicide rate has dropped since 2002 (by 13%) the Highland rate remains one of the highest mainland suicide rates and yet waiting times for

1 The suicide rate in Scotland is almost double that of England and Wales (Highland Council 2009)
psychology services remains high (NHS Highland 2009). There may also be a gendered dimension here, with male suicide rates higher in some remote and rural areas of Scotland compared with the rest of the country (Stark et al., 2006). Additionally, rates of retention in terms of specialist mental health professionals remain challenging, impacting directly on the ability to deliver services to outlying rural areas (Scottish Government 2003a)². For instance, the number of Mental Health Officers (MHO) in Highland for 2008 was 41 but by 2012 this had dropped to 29 (Scottish Government 2012a).

Aside from quantitative indicators, there remains limited qualitative research on the lives of rural service users (Parr et al., 2004). According to Letvak (2002) there are particular challenges to living in rural communities with a mental health problem, most notably limited access to resources and healthcare, and also the dominance of traditional cultural belief systems. Rural settings also present challenges in terms of the uptake of services, due to the prevalence of stigmatising attitudes from local residents and the challenge of maintaining client confidentiality (Fuller et al. 2000; Crawford & Brown 2002). Some academics have therefore called for further research that interrogates the roles of psychiatric service delivery and service user networks in combating isolation, thereby contributing to critical thinking on social exclusion and how it can be mitigated in a rural context (Parr et al., 2004). Given the policy drive to deliver services in locally appropriate ways, the importance of rural mental health research is, therefore, both timely and necessary. Particular attention needs to be given to understanding stigma processes (that can compound social exclusion) in rural areas in order to assess what impact this has in terms of everyday life for service users given the potential for social isolation that exists.

The conceptual framework for this thesis is that of social inclusion. Social inclusion is a central feature in the modern mental health landscape. As a concept it is associated with employment, good housing, access to supportive relationships and participation in the economic and social life of society; it therefore invokes notions such as citizenship, justice and human rights (Boardman 2010). In terms of its theoretical development, it has been influenced by perspectives on disability and rehabilitation, as a result of increased functional independence (Martin & Cobigo 2011).

In the UK policy landscape, social inclusion has featured high on the mental health agenda, as a way to address its social and economic impact. The Social Exclusion Unit’s

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² Data from 2003 noted that there were 13.5 consultant psychiatrist posts in Highland with a vacancy rate of around 22%
The 2004 report *Mental Health and Social Exclusion* firmly established social inclusion as a key policy driver; focusing particularly on early intervention, employment and social participation as ways to overcome the social exclusion of mental health service users. In Scotland, there is also an increasingly high policy priority towards tackling the problems of social exclusion for mental health service users. The national mental health plan ‘Delivering for Mental Health’ (Scottish Government 2006a) promotes social inclusion as the way to address social inequalities in mental health. In addition, campaigns such as ‘See Me’ (www.seemescotland.org) have been developed by the government to tackle the problems of stigma and discrimination that can compound the social exclusion of mental health service users. However, on-going evidence of mental health stigma and discrimination (Scottish Association for Mental Health 2013) leaves questions as to how effective such policies are. Moreover, despite its prominence, there remains considerable debate as to what the concept of social inclusion means and how it can be measured.

Closely aligned to the policy of social inclusion is the concept of *recovery*. This concept has emerged as a significant paradigm in the field of public mental health services (Jacobson & Curtis 2000), influencing how services in the future will potentially respond to, and support, those who need it. The Department of Health’s 2001 statement on its vision for mental health care highlights the centrality of recovery both for policy and practice (Department of Health 2001a). In Scotland, recovery has become central to the government’s vision for mental health services. The aforementioned national mental health plan ‘Delivering for Mental Health’ states: ‘*We must ensure that we deliver on our commitments in respect of equality, social inclusion, recovery and rights. Doing this is central to our vision and to the success of the plan*’ (Scottish Government 2006a, p. vi) demonstrating the increasingly central role recovery plays in terms of policy direction. More recently, the government’s consultation paper on its new mental health strategy continues to highlight this commitment (see Scottish Government’s 2011c *Mental Health Strategy for Scotland: 2011-15*). Initiatives such as the Scottish Recovery Network (www.scottishrecovery.net) have been set up to make information about recovery more accessible, and tools such as the Scottish Recovery Indicator (SRI) have been rolled out as a way of measuring the degree to which services are recovery-orientated.

In terms of its theoretical exposition, recovery highlights the importance of finding meaning and value in life for those with mental health problems, in order to heal and grow beyond the diagnostic label. It essentially links to the importance of hope, gaining control and having a sense of self for those who experience mental health problems
(Repper & Perkins 2003). It suggests a ‘self-directed’ process rather than an end point (Deegan 2002). Indeed, in relation to the study’s theme of social inclusion it is arguable that both are intricately linked (Mental Health Foundation 2013a) given that opportunities are a prerequisite for both concepts. However, there are concerns about the meaning of recovery in such a specialised context and also how to implement recovery-orientated practice based on the current knowledge base (Davidson et al., 2006a).

In addressing the social and economic costs of social exclusion, the concept of social capital has been promoted in health and social policy within a number of different countries. Social capital focuses on the nature and benefits of supportive social relations incorporating notions such as relationships, norms and trust as part of its theoretical exposition (McKenzie & Harpham 2006). It essentially describes the benefits and value of social networks. In Scotland, policy documents such as ‘Towards a Mentally Flourishing Scotland (2009)’ set out key commitments by the government that aim to build the capacity of local communities. From this perspective, building strong social cohesion through civic engagement encourages healthy, functioning communities that can potentially reduce the incidence of mental health problems. The idea of building sustainable communities at the local level (through social capital) has strong links with the policy of social inclusion because better connected communities can engender a sense of belonging and can create opportunities for participation. More generally, the focus on localism is a key part of current UK government thinking (integral to ‘Big Society’ discourse).

Nevertheless, since its inception in the academic world, social capital has continued to provoke debate around its definition and how it can be measured. For some commentators, an increasing interest in the concept has begun to obscure its understanding creating confusion around its application within different contexts (Hean et al., 2003). In addition, there are concerns that the measurement of social capital does not match up to the theory (De Silva 2006). However, in terms of mental health, social capital has been promoted as a resource that can potentially reduce social exclusion and stigma. As a concept, therefore, it has potential to be defined in terms of availability of social, cultural and economic resources and the intensity with which different sections of society make use of them. In the context of rural mental health and social inclusion, it can play a key role because it can facilitate access to a variety of these resources for those who have historically been marginalised. Nevertheless, despite its influence at policy level, the evidence base remains limited (De Silva et al., 2005). Further research is,
therefore, needed on its relationship to mental health in order to understand how it can improve mental health outcomes, particularly for those living in rural areas.

1.2 Voluntary Sector

In the UK, the transfer of care from the asylum to the community, as a result of the policy of deinstitutionalisation, has had significant implications for mental health services. In particular, it has meant that a variety of primary and secondary agencies are now involved in providing care for those affected by mental health problems. Primary care involves treatment services and preventative activities delivered by primary care professionals (e.g. Psychiatrist, General Practitioner (GP), Community Psychiatric Nurse (CPN), Occupational Therapist (OT), Psychologist, Community Mental Health Teams (CMHTs), Emergency Departments, NHS Direct, etc.) whilst secondary services are available in the form of community-based social, housing and voluntary sector services (e.g. Community Day Services, Supported Employment Schemes, Befriending Schemes, Advocacy, Self-Help and Peer-Support groups, etc.).

To this end, the role of the voluntary sector is salient to any discussion on community-based mental health services. Voluntary sector organisations can be defined as those which are ‘formally constituted, independent of (central and local) government, self-governing, not profit distributing, primarily non-business and that benefit from voluntarism’ (Charity Commission 2004). In the modern mental health landscape, the voluntary sector operates alongside the private and public sectors in providing health and social care within the community. Key areas of service provision include self-help groups and community health groups (Milligan 2000).

In recent years, economic constraints around government resources have led to an increasing reliance on the voluntary sector to fill the gap left by formal services (Fyfe & Milligan 2003a) and to act as a substitute for more formal services in rural areas (Woolvin & Rutherford 2013). Nevertheless, there is limited research exploring the contribution of voluntary mental health groups in terms of the role they play in helping rural service users, despite a policy of deinstitutionalisation that has spanned decades.

As a result, it (i.e. the voluntary sector) offers an important site for research on mental health services in rural areas. For rural populations, voluntary sector organisations are often pivotal to community life, providing a flexible and responsive service at a local level (Highlands and Islands Enterprise 2002).
1.3 Rurality and Mental Health: Beyond the UK Context

In order to explore generic issues versus the influence of context, the study was not limited to one type of rurality (Scotland) but also looked at mental health in the context of rural Alberta, Canada.\(^3\) Like the UK, Alberta has a long established policy of deinstitutionalisation which has resulted in a variety of community-based mental health services that provide support to service users. In a similar way to the UK, Canada has also embarked on a policy of recovery for its mental health services. In terms of statistics approximately 16% of the population access help for mental health support each year (Alberta Health Services 2013) making mental health treatment and support a key issue. Moreover, in a similar way to the UK, the province is also experiencing cost-cutting measures in terms of its public health services (Church & Smith 2008). There are also historical links between the two countries (Scotland 2004) which make comparisons useful. However, there are key differences; the sheer size of the landmass in Alberta can mean ‘rural’ is something that is experienced by participants in quite different ways compared to Highland. Moreover, the empirical sites used in this study are relatively new in comparison to Highland. This raises important questions around the nature of entrenched historical links in shaping community attitudes towards those who are considered ‘different’.

1.4 Cross-National Comparisons

Comparative research methods are an established way of identifying and analysing similarities and differences across societies. In recent years, there has been a growing interest in this approach at government level due to increased globalisation and international cooperation. As Hazel (2008) notes, policymakers are particularly interested in cross-national learning as it offers the potential for ‘policytransfer’ in which ideas, policies and programmes can be adopted by one country from another (Dolowitz & Marsh 2002).

There are a number of benefits to cross-national research; in particular it can contribute to a deeper understanding of the socio-cultural practices of other societies, e.g. see Hantrais (1995). It can highlight knowledge gaps and refine the focus of analysis by offering new perspectives (e.g. see Wilkinson & Pickett 2010).

\(^3\) Rural communities make up about 22 per cent of Alberta’s population [http://www.albertahealthservices.ca/878.asp](http://www.albertahealthservices.ca/878.asp)
As highlighted by Farmer and colleagues (2010) international comparison of rural health not only offer opportunity for transferable ‘innovative’ models that can address local delivery challenges, but also ensures the development of a robust, evidence base at an international level. Whilst there are naturally historical and cultural differences between countries, comparative research offers the opportunity to show whether some differences are attributable to policy development, and, by implication, are therefore open to change.

### 1.5 Aims and Objectives

The concept of social inclusion is a central feature of UK mental health policy discourse and various initiatives and theoretical viewpoints have been incorporated as a way of achieving it for those affected by mental health problems. Nevertheless, there is a lack of research exploring the lives of rural service users in relation to these concepts. There is also a lack of research on the rural voluntary sector (Scottish Council of Voluntary Organisations 2003). Given the predominantly rural nature of Scotland’s landscape, coupled with a policy imperative to deliver services in locally appropriate ways, research that examines this is overdue. The current study explores and compares the experience of rural mental health through the lens of social inclusion, recovery and social capital in both Scotland and Canada.

According to Lorenz et al. (2004) there are two broadly defined ways of approaching rural mental health research. One is to capture the entire range of potential mental health conditions in order to single out those with an increased prevalence in rural areas. The other is to focus on distinctly vulnerable rural populations and then trace the implications of their circumstances for subsequent mental health problems. Whilst the research is interested in capturing whether ‘rural’ protects or exacerbates, it does so in relation to those with existing mental health problems. Thus, the research objective is to capture the voices of rural service users (and providers) in order to contribute to and expand the limited knowledge base on rural mental health. This will be achieved by meeting the following two aims:

1. To explore the impact of rural life for mental health service users’ daily life and access of services

2. To understand the contribution of rural mental health services to tackling social exclusion for service users
1.6 Thesis Structure

The current chapter has demonstrated a number of gaps in the knowledge base and hence the importance of qualitative rural mental health research. The following outlines the remaining chapters:

Chapter Two presents the relevant background literature of the research field, framing the subject matter within wider debates in both the UK and Canada. The chapter describes historical and current approaches to mental health and considers the implications of being labelled mentally ill. Given the conceptual framework of social inclusion for this thesis, the chapter also explores the multiple meanings and tensions that surround the term and how it has been understood and applied in the context of mental health. Further, the chapter considers the emergence of the concept of recovery, highlighting some of the ways it has been both welcomed and challenged. The chapter also explores the concept of social capital and outlines the contributions of two key protagonists in the field. Further, social capital is explored in relation to mental health and its role in rural areas. A key dimension for the current thesis centres on the contribution of rural voluntary groups. The chapter, therefore, considers the role of the voluntary sector and describes the changing relationship between the state and voluntary sector organisations, before considering the sector in relation to rural mental health. It will also explore the literature in relation to rural health professionals, identifying some of the challenges of practicing in rural areas. This thesis offers a cross-national comparison with Alberta, Canada. The chapter, therefore, examines the contemporary picture of mental health in Canada before looking more specifically at rural areas. Finally the thesis questions, derived from the gaps identified in the wider literature, are presented at the end of the chapter.

Chapter Three sets out the qualitative methodology used in this study, outlining why such methods (i.e. focus groups and semi-structured interviews) are suitable based on the identified research questions. The chapter outlines the justification for the research design and presents general area profiles (for both Highland and Alberta), along with an overview of the socio-political landscape for both countries. The participant recruitment procedure is identified and the research methods adopted are presented. The chapter also considers the ethical issues that come with doing mental health research. Finally, the chapter identifies the theoretical position of the data analysis, along with the stages involved.
Chapter Four presents a qualitative analysis of the themes identified from the detailed thematic analysis of focus group discussions with service users and semi-structured interviews with service providers. These are framed around the rural experience (Research Question 1) for Highland, Scotland and Alberta, Canada. The challenge of stigma, the impact of community attitudes and cultural factors are discussed. Key differences are observed between Highland and Canadian participants with respect to stigma and community attitudes. The complex ways in which participants conceive rural places is considered and an analysis of service user narratives is presented.

Chapter Five focuses on themes identified from the service provider interviews and highlights the numerous challenges they currently face in Highland and Alberta (Research Question 2). The chapter focuses on issues such as professional isolation and the overlap between the public and private domain which can make practicing rural demanding. It also highlights the way in which the rural dimensions of professional practice require innovative thinking in response to localised problems.

Chapter 6 presents a detailed analysis of the themes identified in relation to research question three and four. In understanding the benefits of membership to rural mental health voluntary groups (Research Question 3) and exploring the differences between the voluntary groups and other rural mental health services (research question 4) the chapter links the data with the concept of recovery, presenting a critical engagement of how the process is facilitated and promoted by the voluntary groups.

Chapter Seven interprets the role and benefits of attending a voluntary group using the lens of social capital (Research Question 5). The chapter focuses on the key concepts of bonding and bridging, demonstrating the numerous ways rural voluntary organisations connect members to each other and their communities. Key differences between Highland and Canadian organisations are noted.

The conclusions emerging from the study are presented in Chapter Eight alongside theoretical and policy implications. The chapter discusses the strengths and limitations of the study and suggests areas for future research.
CHAPTER 2

MENTAL HEALTH SERVICES AND SOCIAL INCLUSION (IN REMOTE AND RURAL AREAS): LITERATURE REVIEW
2.1 Introduction

This chapter explores the available literature on social inclusion, recovery, social capital and the voluntary sector, in order to highlight current thinking and key debates. It discusses these with reference to mental health and rurality and therefore highlights the gaps this thesis addresses.

The chapter begins by exploring the ways in which mental disorder is defined and understood. It then explores a number of paradigms that have been used to frame mental health, including social inclusion, recovery and social capital. As highlighted in Chapter One, despite official pronouncements in relation to policy in each of these areas, on-going evidence of stigma and discrimination faced by mental health service users raises questions as to how much has actually been achieved in terms of mental health outcomes. Finally, the chapter will examine the role of the voluntary sector and its place in relation to mental health service provision in the modern community care landscape.

2.2 Framing ‘Mental Disorder’

This thesis is focused on community-based mental health care. It is therefore important to explore societal approaches and responses to mental disorder. The onset of mental health problems can cause untold pain and disruption both for the individual and for those that care for them (Repper & Perkins 2003). Within the legal framework, it is the only time (other than through criminal activity) that a person can be compulsorily detained and denied their liberty. Yet, the literature demonstrates (see below) a constantly shifting and changing relationship between the ‘normal’ and the ‘abnormal’ which is largely context-specific. Given the socially constructed nature of how mental disorder has been framed (Hinshaw 2007), crucial questions arise around what exactly is meant by disorder and how is it defined.

The conceptualisation and definition of mental disorder in the western world is something that has changed over time and remains, to some extent, controversial. For example, in ancient Greece the predominant belief was that individuals became mentally disordered as a direct result of the gods having taken their minds (Hinshaw 2007). This moralistic view was also apparent in medieval times, with mental affliction indicating the bearer was heretic and weak. From the 1200s, mentally disordered individuals were labelled as
‘lunatics’, signalling a belief that mental ill-health was linked to phases of the moon (Hinshaw 2007, p. 60).

In the following centuries, the mentally disordered were framed as ‘idiots’ or ‘imbeciles’ and banished to institutions often located in the countryside (see The County Asylum Act, 1808); hidden because of the shame associated with mental illness (Bewley 2008). Paradoxically, it was not uncommon for residents of such institutions to be the evening’s viewing entertainment by the public (Hinshaw 2007). In the Victorian era, a moralistic tendency towards mental disorder meant that individuals were blamed and punished with a loss of liberty (although it was still accepted that their sense of reason was not entirely incapacitated). The framing of mentally disturbed behaviour as deviant meant that patients were stigmatised as ‘quasi-criminal’ (Gostin 1975, p. 5) and ‘deficient’ (see Mental Deficiency Act 1913).

Whilst conceptualisations of mental disorder in Europe and the United States had progressed since the earlier witch-hunting and the demonological perspectives of the sixteenth century, the late 1800s still presented challenging conditions for those who needed help for mental disorder (e.g. see Clifford Beers’ A Mind That Found Itself (1908)). In terms of ‘socially constructed’ conceptualisations of mental disorder (Slade 2012, p. 88) it was not uncommon for women to be held in such places if they were found to be unmarried and pregnant, or if they were prostitutes (Leishman & DiDomenico 2009).

In terms of social construction, some authors lay more emphasis on the social tolerance of mental disorder in more liberal communities (i.e. Native American and Lapland cultures) as a background against which individual symptoms appear less extreme and threatening; support for those with mental health problems can involve the whole community (Repper & Perkins 2003, p. 7).

Since the policy of deinstitutionalisation, and particularly from the 1960s onwards, definitions of mental disorder have reflected a more progressive approach, framed within the medical model, with terms such as ‘service user’ and ‘consumer/survivor’ entering the mental health lexicon. Legislation such as the Mental Health (Care and Treatment) (Scotland) Act (2003) and the Mental Health Act (2007) (covering England and Wales) also reflects a more enlightened view. The legislation seeks to ensure that the rights of service users are closely safeguarded through Mental Health Tribunals, advocacy and adequate care planning (e.g. Care Programme Approach). In terms of language and
definition, whilst ‘mental disorder’ was once used as a generic term for both ‘mental illness’ and ‘mental handicap’, within the 2003 Act, one can see that it is still used in this way (although instead of ‘handicap’ the term used is ‘learning disability’). In particular, ‘mental disorder’ is taken to mean any mental illness, personality disorder, or learning disability ‘however caused or manifested’ (Mental Health (Care and Treatment) (Scotland) Act 2003, p. 240).

2.2.1 Current Practice

Understanding how mental disorder is framed remains of crucial importance because it raises key questions about the standards that are used to judge whether a person’s mind is functioning as it should. The current diagnostic system used by mental health practitioners is underpinned by a symptom-based definition (Qualls 2002) commonly based on the WHO’s *International Statistical Classification of Diseases and Health Related Problems* (ICD-10) and the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV). The DSM defines mental disorders as clusters of symptoms that often coexist in particular patterns and that cause personal distress (Qualls 2002). According to its definition, the pattern or syndrome must not be an acceptable and sanctioned response to an environmental or circumstantial event and the behaviour must be perceived as a biological, behavioural, or psychological dysfunction of the individual, in which the conflict with societal norms arises as a symptomatology of the dysfunction (DSM-IV).

However, an important critique of the DSM-IV by Hinshaw (2007) is that the categories are static, consisting of symptom lists and commonly associated features but lacking a true appreciation of the dynamic, fluid nature of mental disorder. Other criticisms suggest its ‘catch all’ criteria make all people potentially classifiable into a variety of the categories (Warelow & Holmes 2011). Fulford *et al.* (2005) also maintains that defining mental disorder is value-laden: the current diagnostic standards are therefore evaluative rather than factual in form. In addition, the symptom-based approach allows for new disorders to be included and older ones dropped, often under the influence of various social movements; the DSM is then based less on scientific decisions and more on political ones (Flaskerud 2010). In *The Psychopath Test* Ronson (2011) highlights the flexible nature of how mental disorders have historically been included in the DSM. In

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4 ‘mental disorder’ was used for a period in the 1970s as a generic term for both mental illness and mental ‘handicap’, by charities such as MIND
discussing the meetings that were held between psychiatrists and the editor to formulate DSM-III, he notes, ‘Someone would yell out the name of a potential new mental disorder and a checklist of its overt characteristics, there’d be a cacophony of voices in assent or dissent, and if [the editor] agreed...he’d hammer it out then and there on an old typewriter, and there it would be, sealed in stone’ (Ronson 2011, p. 250). Given the influence of the DSM to reorient thinking around manifestations of sadness and anxiety, sexual activities, etc. (Bracken & Thomas 2010) such criticisms should not be easily dismissed.

2.2.2 Defining Mental Disorder

The terms ‘mental disorder’ and ‘mental illness’ have generally been framed by the medical model (Reed et al., 2009). Within this paradigm, all illness is considered pathological; psychosis and emotional distress are defined in terms of disordered individual experience, with social and cultural factors featuring little in the way of clinical explanation. Research contributions have largely been from psychiatry and clinical psychology which have served to influence bodies such as the World Health Organisation (WHO) in terms of their policy and service guidance. It is worth noting that terms such as ‘mental illness’ and ‘mental disorder’ are often used interchangeably (see Crisp et al., 2000) with no strict definition which distinguishes between the two. This thesis will use terms such as ‘mental health problems’ and ‘mental ill-health’ in order to remain distant from the largely deterministic connotations of disorder or mental illness.

However, sociological contributions in the literature lend themselves to more abstract definitions. According to Wakefield (1992), disorder lies on the boundary between the given natural world and the constructed social world; a disorder exists when ‘the failure of a person’s internal mechanisms to perform their functions impinges on a person’s well-being as defined by social values and meanings’ (p. 373). Lilienfeld and Marino (1995) however approach disorder in terms of prototypes, suggesting that there are no criterial attributes in nature. Brülde (2003) conceptualises mental disorders as conditions rather than behaviours or problems. Thus, mental disorders belong to a wider category of disorder that incorporates somatic disorders (body symptoms). Whereas Gert and Culver (2004, p. 417) believe mental disorder to be a clinically significant behavioura or psychological syndrome or pattern that occurs in a person; it is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.
Others argue that the definition of mental disorder represents a form of social construction. Emerging from the anti-psychiatry movement of the 1960s, Szasz’ seminal work *The Myth of Mental Illness* (1960) examines the meaning of mental illness and argues against psychiatry on the grounds that it is a form of social control; medicalization legitimizes coercion in the form of treatment. Diagnosis of ‘mental illness’ is used by authoritative power, according to Szasz, to manage moral conflicts in human relations rather than to treat mental disorder. According to Szasz, there are clear limits in terms of legitimate ‘illness’. Physical, bodily functions are understood and accepted as pathological, whereas the realm of thoughts and feelings are not and therefore cannot be considered as diseases. Instead, they are more accurately characterized as ‘moral’ issues (Bracken & Thomas 2010). His later work also focuses on the notion of legitimacy; diagnoses of mental disorder are accepted as scientific categories when in fact they are merely judgements to support certain uses of power by psychiatric authorities:

‘The paradigmatic exercise of psychiatric coercion is the imposition of an ostensibly diagnostic or therapeutic intervention on subjects against their will, legitimized by the state as protection of subjects from madness and protection of the public from the mad. Hence, the paramount source of psychiatric domination is force’ (Szasz 1997).

Opposing the moral and scientific foundation of psychiatry, Szasz’ work defends the individual’s right to be different, to engage in unconventional behaviours and not to be viewed as mentally diseased (Haskell 1995). The idea that mental illness should be considered as an illness by society, and then approached using the medical model, is particularly problematic for Szasz as it does not relate to anything within the mind, as he suggests, ‘the term ‘mental illness’ is a semantic strategy for medicalizing economic, moral, personal, political, and social problems’ (Szasz 2003, p. 115).

Whilst such work remains influential (Haskell 1995; Roberts 2007; Breeding 2010) the idea of mental illness as ‘myth’ has been criticised for its unrealistic premise in relation to the intentions of mental health professionals (Clarke 2009) and for ignoring the role of genetics in the formation of mental disorders (Gert & Culver 2004). The theory is also criticised for its defence of fee-paying psychiatry, excluding large swathes of the population (Clarke 2007).
2.2.3 Implications of being labelled mentally ill

Mental illness is complex and multidimensional; ranging from a vague sense of psychological distress, to specific medical diagnoses and behavioural disorders (Lorenz et al., 2004, p. 75). If mental health problems do develop, and a person is labelled ‘mentally ill’, it can have a negative impact on employability and opportunities to access services and social networks; leading to economic deprivation and social isolation (Knapp et al., 2007, p. 2). The label “mentally ill” can lead to a downward spiral, whereby poverty and mental illness compound each other (Tiffin et al., 2005). In a survey exploring public attitudes to mental health problems in Scotland, Braunholtz, et al. (2004) found that respondents who had a low income, or who lived in relatively deprived areas were more likely to say they had experienced a mental health problem. Epidemiological studies have repeatedly shown that the very poor are at highest risk for many pathological conditions, including mental disorder (Albee & Ryan 1998). Such evidence suggests that mental ill health can be a consequence of, or a causative factor (i.e. the onset of mental ill health can adversely affect a person’s socio-economic status) in relation to the external environment.

There are also legal implications of being labelled mentally ill. In the United States, the eugenics movement of the early twentieth century (advocating restrictions on the reproductive rights of those with mental disorders) led to legislation that sanctioned forced sterilization for those who were deemed mentally retarded or insane (Black 2003). Such responses also featured in Hitler’s domestic policy in Germany (Law for the Prevention of Genetically Diseased Offspring 1933).

Such events are not confined to an historical narrative. The rate of custody loss for mothers with a mental health problem is still high (Miller & Finnerty 1996). Moreover, despite the serious implications of separating parents from their children, mental health nurses involved in Parenting Assessments within some in-patient psychiatric facilities in the UK, are not provided with any specific training for such assessments (Rutherford & Keeley 2009).

In Mark of Shame, Hinshaw (2007) also highlights the psychological impact for the individual from negative societal responses; most notably stigma. However, Hinshaw also suggests that those who experience mental health problems often hold the same negative stereotypes as the general public. Thus, those who experience mental ill health are more likely to try and conceal their illness thereby reducing their willingness to seek
treatment. The expectation that they will be stigmatized can lead to secrecy, withdrawal and isolation that ‘decreases the chances of adaptive responding in society’ (Hinshaw 2007, p. 104). For some, the process of being labelled mentally ill is compared to that of a bereavement, involving the ‘loss of the privileges of sanity’ and of the loss of previous concepts of self (Repper & Perkins 2003, p. 17). Such evidence points to the social magnitude of being labelled mentally ill.

Nicholson and colleagues (1998) found that stigma was still an on-going problem in the context of parenting. As one mother noted, ‘I guess I feel that if I got pregnant, my child would be taken away from me because I have a mental illness. I feel like I’m sterilized by the department of social services and have no rights’. In recent years, despite evidence of women with a serious mental illness being more involved in the parenting of their children (Ritsher et al., 1997), a survey by Read and Baker (1996) found that 48% of women felt that their parenting abilities had been questioned (often by professionals) because of their mental health problem. Some were told not to consider having children because of their diagnosis. The implication is that the heritability of illnesses like schizophrenia had coloured the attitudes of some professionals.

2.2.4 Section Summary of Approaches to Mental Disorder

Historical approaches to mental disorder are useful to note in order to understand the origins of current perspectives and conceptual frameworks. However, a definition of mental disorder that is satisfying at clinical, scientific and philosophical levels continues to be elusive (Hinshaw 2007). Nevertheless, it is important to highlight the changing nature of how mental disorder is framed, and the serious implications of being labelled ‘mentally ill’, emphasising the large extent to which it is socially constructed as distinct from physiologically determined. As previously noted, this thesis will use terms such as ‘mental health problems’ and ‘mental ill-health’, whilst participants will be referred to as ‘service users’.

2.3 Social Exclusion/Inclusion

An overarching theme for this thesis is the concept of social inclusion, given its prominence in mental health policy (see Chapter 1). Social inclusion focuses on social and economic participation and incorporates factors such as employment, good housing, and access to services and supportive relationships as part of its conceptualisation. However, there is considerable debate as to what the concept means and how it is
deployed by government. Criticisms suggest it ignores structural processes that create exclusion and that it may simply be used to reduce welfare dependency (Spandler 2007; Teghtsoonian 2009). This section starts by exploring literature on the definition of social inclusion (and social exclusion) demonstrating some of the controversy that has followed the concept since its inception in UK social policy discourse. The section then explores how it has been framed within the political agenda. The section will then specifically look at the policy of social inclusion in relation to mental health, before finally narrowing the focus to look specifically at social inclusion in relation to rural mental health.

2.3.1 Tensions in defining social exclusion/inclusion

Discussion on social inclusion in relation to mental health firstly requires an exploration of some of the tensions that surround terms such as ‘social exclusion’ and ‘social inclusion’. Social exclusion has become increasingly used as a concept by politicians, practitioners and members of the public. It focuses on core aspects of deprivation but is recognised as a broader concept than poverty. A central feature of most definitions involves a lack of participation in social, cultural, political and economic activities (O’Brian et al., 1997; Atkinson 1998; Byrne 1999; Percy-Smith 2000; Pantazis et al., 2006; Social Exclusion Task Force 2009). Other themes include links with rights and citizenship (Popay, et al., 2008; Royal College of Psychiatrists 2009); ideas of functionings and capabilities (Sen 2000); participation in consumption and savings (Burchardt et al., 1999) and with social cohesion and solidarity (Béland 2007). Despite its variability, a useful definition is captured as:

‘[Social inclusion] reflects the importance of participating in all aspects of the particular society, and focuses on both the individual and the institutions that enable and constrain social and economic participation. In particular [it] introduces aspects of social and economic participation and citizenship into its conceptualisation’ (Woodley-Baker et al., 2002, p. 1).

Whilst it has generated much debate and a significant amount of literature social inclusion remains a contested concept (Byrne 1999; Shucksmith & Phillip 2000; Levitas 2006). According to Woodley-Baker et al. (2002) a particularly important critique of the concept of social inclusion draws attention to the boundaries constructed around the notion of inclusion and exclusion, essentially creating a ‘fictitious comfortable homogenous group with very little difference within those who are included’ (p. 2). As a
concept it is therefore limited in its ability to confront the broader understandings of inequality within a society. Other criticisms include its overlap with the concept of poverty (Fischer 2011) and that policies designed to tackle social exclusion have reflected a more limited concern with labour market exclusion (Geyer 1999; Béland 2007; Levitas 2007). The problematic nature of the term has led to definitions that offer a more holistic understanding of the concept (De Haan 1999) but it remains unclear how interventions to improve social inclusion can be measured in terms of their success. Indeed, the measurement of social inclusion arguably depends on the criterion used, which in turn links to more fundamental moral, religious and social ideals. Whilst this gives it broad appeal, it also leads to questions regarding its value as an analytical concept (Silver 2007).

2.3.2 Social Inclusion/Exclusion and the Political Agenda

Social inclusion as a term is widely accepted to have originated in France with the publication of *Les exclus* (1974) from where it entered the European agenda (Silver 1994; Levitas 2006). A commitment by the European Union (EU) to tackle the problem of social exclusion and to promote social inclusion has been reflected in a number of treaties, e.g. Maastricht (1992) and Amsterdam (1997). In the former, combating social exclusion was adopted as part of a general aim in EU-regulated social policy; with the Amsterdam treaty further enhancing the social policy agenda in order to combat social exclusion. Since the Lisbon Summit (2000), the promotion of social inclusion has been a central strategic goal of the EU (Levitas 2006).

In Britain, social exclusion emerged in social policy discourse during the 1980s in response to radical economic restructuring and consequent rises in inequality (Silver 1994; Béland 2007). During New Labour’s term (1997-2009), it was central to discussions on social policy and remained a key policy driver (Berman & Phillips 2000; Stewart & Hills 2005). However, whilst attempts to tackle social exclusion remain on the incumbent coalition government’s agenda, the closure of the Social Exclusion Task Force suggests it may not occupy such a central theme. The drive to tackle inequality has more recently been framed around a ‘Big Society’ discourse, which calls for people to be more engaged with their local communities, in order to assume greater responsibility and control. Whilst this relates to the transfer of power and responsibility from central government to individuals and local communities, in terms of social inclusion, it does little in the way of creating the conditions necessary so that all can benefit from such a
transfer of power. In other words, it does not tackle the root causes of social exclusion and inequality (Coote 2010).

Although part of many national and international agendas, that there is no universal definition of social inclusion has implications: if it cannot be defined, how can it be measured? In highlighting the slippery nature of social exclusion Levitas (2006) identifies a model for tracking alternative and shifting meanings. The model distinguishes three discourses with different embedded meanings of social exclusion, its causes and consequent policy approaches. Known as RED, or redistributive discourse, SID, social integration discourse, and MUD or moral underclass discourse, each discourse signifies varying approaches that have been used to tackle exclusion in both a UK and a wider European context. (The MUD model is relevant to the current study and is discussed in Chapter Four). The political discourse about social exclusion and its impact on welfare state restructuring has also been developed by other authors (Silver 1994; Béland 2007) who suggest that the political focus on exclusion, and policies designed to combat it, have served to distract attention away from other forms of inequality more generally. Indeed, collating empirical data from developed countries around the world and from 50 states in the USA, Wilkinson and Pickett (2010) demonstrate a clear link between various social pathologies and levels of mutual trust and social cohesion in societies and identify these in turn with levels of equality in income and wealth. Such work arguably points to a clearer understanding of what is meant by ‘inclusion’.

2.3.3 Measurement of Social Exclusion

There is considerable debate as to how social exclusion can be measured (Levitas 2006; Silver 2007). When relevant and quantifiable indicators of social exclusion are identified, there remain questions about how discrete these are from one another, how they should be weighted and ranked in an order of causal priority. To date there is no agreement about which dimensions have the most significance (Levitas et al., 2007) with Morgan et al. (2007) suggesting,

‘Despite general agreement that social exclusion is multidimensional, there is no consensus on which dimensions are relevant……and whether multiple and cumulative disadvantage is necessary or whether one of the range of deprivations is sufficient’ (p. 479).
Pantazis et al. (2006) have attempted to overcome such methodological problems by exploring the interaction of different dimensions of exclusion drawn from the Poverty and Social Exclusion Survey of Britain (PSE). However, it is clear that methodological attempts to measure or analyse variables are problematic given the lack of a formal exclusion threshold (Silver 2007).

2.3.4 Mental Health and Social Exclusion

It is well evidenced that those diagnosed with a mental illness are particularly vulnerable to social exclusion (Sayce 2001; Repper & Perkins 2003; Baumann 2007; Secker 2009). Those diagnosed are often excluded from employment and education, and are at risk of having no social support (Social Exclusion Task Force 2009). Locked in a perpetuating process, this is often exacerbated by discrimination and loss of status (Sayce 2000). Read and Baker’s (1996) survey found that a third of respondents had been dismissed or forced to resign from jobs due to mental health problems and half felt unfairly treated by health care services. Indeed, people with mental health problems are less likely to be employed than any other group of disabled people (SESAMI 2010). According to the Office of National Statistics, in 2002, approximately half of the disabled population in the UK were economically inactive compared to only 15 per cent for people who were not disabled (Smith & Twomey 2002).

Although the interplay between social exclusion and mental health is complex (Repper & Perkins 2003), a link between the two is well established (Sayce 2001). It is suggested that mental health problems can be both a cause and an outcome of social exclusion (Rankin 2005). As Knapp and colleagues (2007) note:

‘there is a strong relationship between poor mental health and social deprivation, with the causal influences working in both directions….deep-rooted stigma, profound ignorance and widely practised discrimination greatly limit education and employment opportunities for mental health service users, often dragging them down into poverty’ (p. 2).

Indeed, stigma remains a major reason for social exclusion (Royal College of Psychiatrists 2009).

The literature generally points to the idea that exclusion and inclusion exist on a continuum, with the decrease of one leading to an increase of the other. However Secker
(2009) takes both concepts to be separate but overlapping spheres. Social exclusion is seen as operating at a structural level, through barriers that exclude individuals and groups from full participation, whilst inclusion operates at an individual level and relates to the extent to which people are accepted and feel they belong within different social contexts; an approach which is also adopted by other academics (Shucksmith 2000).

In their research on mental health in the Scottish Highlands Parr *et al.* (2004) found that social exclusion was not a fixed state. Participants felt included and excluded at different times, depending on the actions of others in the community; demonstrating that social exclusion is a process that entails a subjective state rather than an objective fact:

> ‘inclusion denotes relations and practices that people with mental health problems perceive to signify their positive involvement in and ‘mattering’ to a local setting....By contrast, ‘exclusion’ denotes more negative eventualities that involve rejection, avoidance and distancing from other community members, such that individuals are ‘made different’ through more or less deliberate social actions reinforcing their problematic mental health status’ (Parr *et al.*, 2004, p. 405).

Most studies consider lack of social and economic participation as evidence of exclusion. According to Schneider & Bramley (2008) social exclusion of service users can be reduced through strategies designed to increase participation and user autonomy. However, given the power differential between service users and experts, contributing to the decision-making process at, for example, policy level, is questionable and can potentially disempower service users (Cowan *et al.*, 2011). It is also arguable that a person with mental health problems can have a job (indicator of inclusion) but still feel excluded by work colleagues due to stigmatising attitudes. Whilst the concept assumes a desirable way of living for all members of society, by implication it suggests that mainstream society is unproblematic: social inclusion, in this way, has ideological overtones (Levitas 2006). In critiquing the concept of social inclusion Spandler (2007) warns of the ‘moral imperative’ implicit within social inclusion discourse. In particular, the way in which it can potentially be used to regulate people with mental health problems; essentially ‘reproducing and legitimising the prevailing socio-economic order’ (p. 12). The policy of social inclusion is, therefore, criticised for ignoring structural forces that are the potential cause of social exclusion. Importantly, work by Wilkinson and Pickett (2010), whose research has spanned 25 years and several nations, suggests a
very strong connection between factors like social inclusion, mental ill health and structural forces like stratification in terms of income and wealth.

Highlighting the complex nature of social exclusion, Schneider and Bramley (2008) suggest it is a *discourse*, rather than a concept, which invokes four dimensions of specialised knowledge (see Figure 1). In terms of *relative disadvantage*, key here is that there are no absolute measures of social exclusion but the threshold is determined by the structures and expectations of society. In terms of its *multifactorial* dimension, social exclusion conveys disadvantage in more than one respect. The *dynamic* discourse refers to the idea that the situation of an excluded person can change. Finally, and most distinctively, social exclusion locates individuals or groups in relation to wider structures of society, so it has a transactional dimension. From this perspective, exclusion limits the interactions that are possible between individuals, families, communities, regions and even nations. Since these interactions are reciprocal, not only the excluded are affected: exclusion affects all of society, for better or worse. This aspect is discussed further in Chapter Seven.

*Figure 1: Four key dimensions of social exclusion (source: Schneider 2008)*
This transactional aspect of social exclusion indicates that remedies cannot be found solely from the perspective of the excluded. Exclusion cannot exist unless someone or something brings it about, be it through inadvertence, the operation of a system (e.g. institutional racism) or active discrimination by individuals. A transactional understanding of social exclusion is of particular importance because it requires the more powerful actors to recognise the part that they play in oppressing the excluded (Schneider 2009).

Boardman (2010) identifies a number of central concepts in relation to social exclusion and mental health which is useful given the conceptual complexity of social exclusion:

<table>
<thead>
<tr>
<th>Box 1. Central Concepts of social exclusion relevant to people with mental health problems and learning disabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A relative concept</td>
</tr>
<tr>
<td>2. Has been applied to a range of specific groups – including those with disabilities</td>
</tr>
<tr>
<td>3. Based on concepts of poverty and deprivation</td>
</tr>
<tr>
<td>4. Emphasizes agency and processes</td>
</tr>
<tr>
<td>5. Has a dynamic dimension</td>
</tr>
<tr>
<td>6. Central role of participation</td>
</tr>
<tr>
<td>7. Multifactorial causal framework</td>
</tr>
<tr>
<td>8. Life course and longitudinal perspective</td>
</tr>
<tr>
<td>9. Links to choice and access</td>
</tr>
<tr>
<td>10. Stigma and discrimination</td>
</tr>
<tr>
<td>11. Equality and human rights</td>
</tr>
<tr>
<td>12. Citizenship</td>
</tr>
<tr>
<td>13. Social capital</td>
</tr>
<tr>
<td>14. Recovery</td>
</tr>
</tbody>
</table>

Source: Boardman (2010)

Studies on social exclusion and mental health often use variables such as housing, income, education, employment and lack of voting power as evidence of exclusion (Barnes 1999; Leonori et al., 2000; Payne 2000; Crowther et al., 2001; Nash 2002; Targosz et al., 2003; Hjern et al., 2004; Social Exclusion Unit 2004; Granerud & Severinsson 2006; Muir et al., 2008; Stenfors-Hayes et al., 2008; Gray et al., 2010;
Thus, the successful outcomes of initiatives designed to tackle exclusion are often measured in terms of service use and opportunities to participate. A number of studies also look at stigma and the impact of negative attitudes as evidence of perpetuating social exclusion for service users (Kurzban & Leary 2001; Corrigan 2004; Baumann 2007; Schneider 2009; Berry et al., 2010). These studies highlight the multidimensional nature of social exclusion.

Some authors have chosen to focus on participation in cultural activities as a way of addressing social exclusion. Secker et al. (2009) carried out an evaluation of introductory arts courses offered to those at risk of mental ill-health and isolation, along with those in recovery. Their themes for measuring inclusion centred on social isolation, social acceptance and social relations. They found that attending courses resulted in significant improvements in wellbeing and social inclusion. Interestingly, service user responses were used in the formative evaluation in order to develop appropriate themes as the research progressed; suggesting the findings accurately reflect what is considered important (in relation to social inclusion) by service users. In a similar vein to Parr et al. (2004) the study focused on the subjective dimension of social inclusion, captured in terms of the degree to which participants felt accepted or isolated.

Stickley (2010) also explored service user engagement with art programmes as a form of social inclusion. The researcher interviewed mental health service users three times over a one-year period using a narrative approach. The study found that a sense of belonging was a key outcome and consequence of being involved in arts programmes. Also, the opportunity to be creative and engage with others within an arts context, allowed participants to create a positive identity constructed around that of artist, i.e. it allowed participants opportunities for self-expression and connectedness which allowed them to assert a more positive social identity.

Some studies on mental health make generalised associations with social exclusion (see Hjern et al., 2004 who use the concept interchangeably with social adversity and social marginalisation) and there is an overlap with concepts such as poverty (Perron et al., 2010). Nevertheless, many of the studies investigating mental health and social exclusion do not provide adequate definitions. A number of these studies do not directly investigate links between the two, particularly in terms of indicators of exclusion as highlighted by Morgan et al. (2007) in a systematic literature review that excluded all but 12 out of 232 papers due to a lack of definition of social exclusion and issues around its measurement in relation to mental health.
According to the Social Exclusion Task Force (2009) exclusion refers to ‘a combination of problems, such as employment, discrimination, poor skills, low incomes, poor housing, high crime and family breakdown’. However it is arguable that in terms of mental health, such definitions are mainly limited to resources, such as having adequate housing and stable employment. Sayce (2001) provides a more nuanced definition linking the impairments experienced by those with mental health problems with societal responses. As she suggests,

‘We can conceptualise social exclusion in relation to mental health service users specifically as the interlocking and mutually compounding problems of impairment, discrimination, diminished social role, lack of social and economic participation and disability’ (p. 122)

Despite major legislative changes in the UK, most notably from the 1990s, evidence suggests that those who experience mental health problems still do not feel included in society. The policy of deinstitutionalisation, whilst ensuring a more ‘user-led’ approach has not necessarily led to greater social participation (Granerud, & Severinsson 2006; Muir et al., 2008). According to Secker et al. (2001) some mental health services have actually maintained segregation by focusing on specialised support only for those who experience mental health problems. Repper and Perkins (2003) develop this point further by suggesting that the proliferation of ‘drop-in’ centres, day centres and social clubs which exist to support those who experience mental health problems in the community, inadvertently ensure social networks are limited to other service-users thereby maintaining segregation. Such places are often devalued by the community, ultimately making it difficult for the service-user to engage in meaningful interaction outside these specialised communities.

A further issue is that mental health problems vary in intensity, duration and aetiology. In relation to social integration, it is arguable that there may be significant differences in the ability of people with chronic psychotic disorders, in comparison to less severe conditions such as depression, to integrate/be integrated in social groups. Crisp et al. (2000) looked at public responses to a range of disorders (severe depression, panic attacks, schizophrenia, dementia, eating disorder, alcohol addiction and drug addiction) and found that schizophrenia, alcoholism and drug addiction elicited the most negative opinions, with many respondents rating people with these conditions as unpredictable and dangerous to others; suggesting this may have implications in terms of social inclusion
for service users within their local communities. Diagnoses such as eating disorders and panic attacks attracted less negative opinions.

Section 2.3.4 has highlighted some of the key debates and challenges associated with linking mental health to the concepts of social exclusion/inclusion. Work by Parr et al. (2004), Secker et al. (2009) and Stickley (2010) offer important contributions to the academic literature by highlighting the more abstract dimensions of ‘feeling included’ that move away from formal indicators. The current thesis also aligns itself with these approaches (see section 2.3.8 for working definition of social inclusion).

2.3.5 Rhetoric and Reality

There has been a general shift towards prevention in the UK mental health policy landscape. Underlying this direction is an emphasis on social exclusion and ways to combat it. Early strategies such as the National Service Framework for Adult Mental Health (Department of Health 1999) signalled this policy direction with a clear commitment to social inclusion through a more integrated framework for service delivery. The Framework set out ambitious targets for government over a 10 year period, reflecting the status of mental health as a key health priority. Leading on from the Framework, the single most important document to herald the move towards social inclusion in recent years has been the Social Exclusion Unit’s 2004 report Mental Health and Social Exclusion (SEU 2004). In particular, the report flagged areas such as early intervention, empowerment and rights, employment and social participation as ways to promote inclusion and to combat social exclusion. As a consequence of the report and the 2007 Comprehensive Spending Review, Public Service Agreement 16 (PSA 16) was the first agreement that focused specifically on the needs of the most vulnerable adults (Social Exclusion Task Force 2009). Agreed targets included increasing the rates of settled accommodation and of employment, education and training for the most vulnerable adults. (Since that time, the current coalition government no longer use Public Service Agreements, opting instead for each government department to set its own objectives and deadlines).

However, the gap between such official pronouncements and actual policy implementation is noteworthy. In relation to the National Service Framework, implementation was found to be slow, and the impact of its targets questionable (Rankin 2004). Additionally, the mismatch between officially announced levels of funding and what was actually received is noted (Boardman & Parsonage 2008). A formal evaluation
by the Commission for Health Improvement also found some mismatch between official targets from the Framework and service user perceptions of the service received (Commission for Health Improvement 2003). In relation to Public Service Agreement 16, given the rates of unemployment amongst mental health service users, it is questionable whether such targets were achieved (the employment rate for people with mental health conditions, excluding depression, is estimated to be between 10% and 16%, Department for Work and Pensions 2009). In a recent report by a service user group it was found that poverty remained a reality for many service users due to challenges with sustaining paid employment. Specifically, low income meant there was not always enough money to pay bills and buy food, or to socialise (Highland User Group 2011).\(^5\)

Despite endorsements to ensure greater service user and carer involvement in policy and planning, service users still feel left out of the process, suggesting efforts to engage their opinions may simply equate to tokenism (Beresford \textit{et al.}, 2005). In the current policy landscape, there is growing concern amongst service users that their voices are still not heard despite the significant and major reforms that are occurring in social policy given how they will be affected by them (Beresford & Andrews 2012).

In Scotland, the Government has also demonstrated its commitment towards tackling social exclusion for those who experience mental health problems. Policy documents such as ‘Towards a Mentally Flourishing Scotland’ (2009) and ‘With Inclusion In Mind’ (2007) highlight key areas (such as employment and service user involvement in service development), to highlight this commitment. Such direction is arguably linked to current estimates that suggest the social and economic costs of mental health problems in Scotland has risen to £10.7 billion, an increase of nearly a quarter on figures from 2004/05 (Scottish Association of Mental Health 2011).

However, research evidence on social exclusion and mental health in Scotland demonstrates that people with mental health problems continue to be marginalised, leading to questions around how effective changes in policy have been. The Scottish Association for Mental Health (SAMH) found that people who use mental health services in Scotland were more likely to live alone, less likely to have a partner, and less likely to be in employment. In terms of social contacts, they were less likely to see friends, family or colleagues compared to the general population. Fewer than half of respondents felt that mental health services were encouraging them to use other community services,\(^5\)

\(^5\) While these policies and initiatives are UK-centric, there are also European directives (see Mental Health Declaration and Action Plan for Europe, WHO European Region 2005).
despite the importance of social integration for rehabilitation (Scottish Association for Mental Health 2006). Many also still feel that their voices are not heard within the legal system (Ridley et al., 2009). Such evidence reinforces the need for effective context-specific health policies and initiatives which are both targeted and linked with broader social inclusion agendas and that reflect the concerns of service users themselves.

2.3.6 Social Exclusion and Rural Mental Health

There is a lack of rural mental health research in the UK (Nicholson 2008). Given the rhetoric of ‘user involvement’ in policy and planning, and of putting users’ needs at the centre of design and delivery (Tait & Lester 2005) this gap is concerning because a lack of understanding of the role rurality plays in the lives of service users leads to questions on whether policy reflects their needs. Despite mixed results from epidemiological studies comparing rural and urban areas (Eckert et al., 2006; Kiani et al., 2013) there is a general consensus that rural areas fare better than urban ones in terms of mental health (Nicholson 2008) even though rural areas have consistently higher suicide rates for men (Stark et al., 2006).

A possible reason for such discrepancies may relate to help-seeking behaviour in rural areas. In their study of differences in rural and non-rural rates of common mental disorders, including anxiety and depression, Weich et al. (2006) found that the incidence was lower in rural areas. However, they gathered data using the General Health Questionnaire (see also Hutner & Windle 1991; Wainer & Chester 2000; Nicholson 2008) and identified a lack of awareness amongst rural populations around symptoms such as depression. Research by the Rural Poverty and Social Inclusion Working Group (2001) found that mental illness can often remain hidden within families, with members not accessing appropriate support for relatives in order to avoid the rest of the community finding out. In addition, stress, anxiety and depression were often not recognised by rural dwellers as problems that required treatment and practical support, suggesting that available figures on prevalence of mental health problems may not accurately reflect the scale of the problem.

In addressing the hidden nature of mental illness in the Highland region, one professional noted the following:
‘As a social worker […] I have worked with many Highland people who have experienced trauma in their childhoods […] I would say that the majority […] have significant […] mental health issues stemming from their early years […]. Many […] witnessed on-going domestic violence […]

As services we need to get better at working in partnership with mental health services, much of the time people are being referred to agencies which support them with the manifestations of their difficulties […] rather than receive a service for their underlying mental health issue […] I would say that people [in the Highlands] mask their mental health issues with many types of behaviours and as such the real reasons for their difficulties goes unaddressed (Area Manager 2013, personal communication).

The above quote highlights the hidden problems of mental health in the Highlands and thus the need for more rural mental health work. It also suggests that official statistics may not capture the prevalence and breadth of its impact for those living in the area. Indeed, in terms of official statistics, comparative rates of referral to mental health services in urban and rural settings remain challenging to capture. One public health professional who was contacted as part of the study noted that there was no electronic collection of Community Mental Health Team referral data in Highland by public health (Public Health Consultant 2013, personal communication). Again, such evidence points to the need for more in-depth research on rural mental health in the Highlands.

2.3.7 The distinct challenges of rural areas in the context of mental health

Hutner and Windle (1991) set out some of the unique challenges of rural areas in the context of mental health. Some of these challenges centred on the lack of: resources, high quality research, awareness amongst rural populations of symptoms of depression, adequate support in providing and organising mental health services through the Community Mental Health Centres (equivalent to Community Mental Health Teams in the UK), and the psychological suffering that can be brought on in rural areas through, for example, farming crises. They also note the challenge of making mental health services both accessible (given the widely dispersed nature of the population) and acceptable to rural dwellers.
Hutner and Windle frame the mental health needs of rural dwellers as distinct from those in more populous places. Wainer and Chester (2000) also highlight a number of challenges (e.g. acute isolation from mental health services). Nevertheless, whilst relative poverty, negative life experiences and a lack of control over work and life are risk factors for mental health problems, these authors contend that some people living in rural places experience these negative aspects more than others. Interestingly, the authors dedicate a significant amount of their discussion to the importance of culture as a key factor in relation to mental ill-health; especially cultural understandings of masculinity associated with hardness and a taboo against help-seeking. The authors also highlight the potential of social connectedness in rural communities as an important aspect of wellbeing. Such ideas tap into themes around social capital which will be discussed in section 2.7.

Nicholson (2008) also sets out the challenges of rural mental health in relation to culture, highlighting issues such the lack of anonymity in small rural communities and stigma which can potentially impact on the level of awareness and consequent help-seeking amongst rural populations (rural culture has resonance with the present study and will be discussed in Chapter 4). Interestingly, in discussing aspects of rural life Nicholson observes the way in which rurality has often been associated with the pastoral idyll, ‘the peace and quiet’ of the rural environment and its associated perceptions of relative safety. A consequence of this rural idyll, however, is that it has masked the disadvantages of living in rural places and has prevented deeper exploration of the reality of rural life. Such assertions can also be found with Philo et al. (2003). In their geographical reading and critique of the rural mental health literature, the authors conclude,

‘few studies explicitly set out with the prime objective of accessing, observing, describing and interpreting the lifeworlds of rural ‘mad’ people, whether to ascertain how they are treated by others around them on a daily basis, tolerantly perhaps but maybe with hostility, or to develop empathy with how these people feel about their lives, neighbours, problems and identities’ (p. 263).

In response to this, Parr et al. (2004) set out to understand these lifeworlds of rural ‘mad’ people. The study, using interviews, focus groups and in-depth ethnographic work, gathered data from 160 service users, service providers and carers in various locations around the Highlands of Scotland. The research found that, whilst a minority of service-
users felt included in their communities, more than half reported feeling social excluded and considered a threat within their communities. The issue of stigma was found to be a major problem, with many respondents avoiding accessing services until they were ‘in crisis’ in order to prevent their problems becoming known by others.

The study found that participants experienced both inclusion and exclusion, highlighting a ‘complex and untidy story of...tolerance and rejection...’ (Parr et al., 2004, p. 414). Instances of inclusion were noted after an acute phase requiring hospitalisation: the local community were found to visit or phone the service user to ensure they were alright. Conversely, enquiries around how the person felt after a stay in hospital were also construed as overly intrusive, demonstrating the complexity around what it means to feel included. Drop-in centres were found to play an important role for service-users, giving them a sense of community and belonging. However, the authors caution that association with such centres can still have negative effects on the standing of the individual within the wider community (Burns et al. 2002a, p. 24). There is a need to examine such findings further in order to understand the role voluntary drop-ins play in a rural setting, to understand how they contribute to service user networks and how they can help to combat social exclusion and isolation for rural service users.

In Norway, Ekeland and Bergem (2006) explored the way in which service users negotiate their identity in rural communities. Using qualitative interviews of 15 people living in four municipalities, the researchers found that those who accepted the identity of ‘mental patient’ had easier access to services, experienced less stigma and fewer conflicts with their environment than those who opposed the role. They found that participants were often socially isolated, lacked employment, had few friends, small social networks and did not participate in the social and cultural life of their communities. In terms of social contacts, many forged friendships with others who also lived on the margins of society. However, despite experiencing varying forms of social isolation within their respective communities, being able to remain in familiar places (most having been born and raised there) was central to interviewee’s sense of belonging and ultimately to their identity.

The study found that participants adopted various ways to project a positive self-image to others in the community; for some this was connected to attending a municipal day-care centre, whereas for others it was through active avoidance of such spaces. Mixed attitudes were also found in relation to using health and social services, and engaging with health professionals. The inherent challenges of using mental health services given
the social proximity of rural communities is highly salient to the current study and is
discussed throughout this thesis.

There can often be a number of difficulties associated with rural living; isolation, lack of
transport, limited services and economic opportunities are common features (Rural
Poverty and Inclusion Working Group 2001; Friedman 2003). In terms of mental health,
services tend to concentrate clinical resources and expertise in large densely populated
areas, leaving limited options for rural inhabitants who are in need of such services
(World Health Organisation 2001). The relative lack of anonymity in remote and rural
areas can also present a major problem for initiatives designed to overcome the problems
of social exclusion for service-users. Indeed the community can potentially remain a
hostile place for people to gain acceptance (Felton et al., 2009). Such sentiments are also
echoed by Parr and colleagues (2004) ‘for rural Highland dwellers, there is a palpable
sense that their lives are never entirely private […] daily practices entail intense
surveillance of all social activity….gossip [sic] is such a pervasive feature of Highland
rural life…’ (p. 7). In such a setting, fear of gossip or appearing ‘different’ can
potentially discourage users from seeking the help they need, thereby exacerbating their
symptoms and increasing isolation. It may also imply that current statistics on mental
health are not truly representative of the scale of the problem (Nicholson 2008) in the
Highlands (see above comment on p. 31).

Despite continued conceptions of the ‘rural idyll’ (Foy-Phillips & Lloyd-Evans 2011)
research by Watkins and Jacoby (2007) found that such idealised conceptions of country
living can potentially contribute to stigma and stress. They found that for those who do
not ‘fit’ it can lead to isolation, and in some cases hostility from other members of the
community. The authors call for more ethnographic research to be carried out in rural
areas to better understand health experiences. Indeed, more qualitative work in general is
needed to understand the rural experience of individuals who have mental health
problems and are consequently viewed as ‘different’ to understand the processes that lead
to service users becoming excluded within their communities and how such challenges
are overcome.

2.3.8 Summarising social exclusion and rural mental health

The knowledge base on social inclusion and mental health suggests that service users are
at greater risk of exclusion, particularly due to stigma and discrimination. These factors,
along with rural issues (e.g. limited service provision and cultural attitudes around help-
seeking) combine to create a unique set of circumstances for rural service users. Yet there is a research lacuna in terms of understanding the experience of rural mental health service users, raising questions around how accurately mental health policy reflects their needs. In terms of social inclusion, the literature review reveals that the term remains somewhat controversial and contested, involving shifting discourses (Levitas 2007). Capturing the voice of rural service users is, therefore, crucial to ensure that mental health policy and practice is aligned to their needs. In response to this, the thesis answers the following research question:

‘What does it mean to experience mental health problems in remote and rural areas?’

This section has highlighted the conceptual complexity of terms such as ‘social inclusion’ and ‘social exclusion’. For the purposes of clarity and methodological rigour the current study will adopt the following definitions:

*Social Exclusion* refers to a situation in which certain members of a society are, or become, separated from much that comprises the normal round of living and working in the society (Philo 2000).

*Social Inclusion* refers to the extent to which people are accepted and feel they belong within different social contexts (Secker 2009).

### 2.4 Rural Service Providers

The present study incorporates the views of both service users and service providers. In doing so, it aims to present a comprehensive picture around rural mental health services. It is necessary to see how service provider issues have been framed in the wider literature in order to identify whether those issues are also present in the current study; ensuring that any policy recommendations made are grounded in a robust evidence-base. The following section, therefore, explores the literature relating to rural health professionals.

In the modern mental health landscape, formal mental health services are generally provided by Community Mental Health Teams (CMHT) which are located in specific sites which rural service users travel to access. Services provided within these teams include psychiatrists, community psychiatric nurses (CPN), occupational therapists (OT), clinical psychologists and counsellors (Royal College of Psychiatrists 2013a). Given the challenge of providing services to dispersed populations, the literature is largely dedicated to looking at barriers that impede access to services. Some studies have
focused on rural dwellers perceptions of specialist mental health support (Deen et al., 2012; Perkins et al., 2013) which is useful given some of the challenges associated with rural culture (i.e. lack of anonymity combined with stigma) identified earlier (see section 2.3.7). Rural services also remain relatively underfunded and yet there are considerably higher costs involved (particularly in providing emergency services for lower numbers of people), both in terms of transport (for professionals and service users) and indirect costs in terms of travel time (Nicholson 2008). In terms of emergency services, significant delays in the transfer of acutely disturbed patients in Highland have resulted in some being held inappropriately in local police cells due to the lack of alternative options (Remote and Rural Areas Resource Initiative (RRARI) (2003).

Evidence from the Mental Welfare Commission (2012) highlights a considerably high use of detention certificates and compulsory treatment orders in the Highland area compared to other Health Boards, potentially linked with the challenges of delivering community care to dispersed populations. Whilst this arguably links with the urge to ‘play it safe’ on the part of GPs and social workers in isolated rural environments, it has significant implications, not only in terms of levels of government expenditure but also in terms of the protection of civil rights and freedoms, thus making such evidence a key mental health issue. Some studies have explored telehealth technologies as a way of addressing the challenges of rural service provision (by redistributing services from areas of greater supply into areas of greater need) (Neufield et al., 2012). Nevertheless, choice for rural service users remains limited (Nicholson 2008).

Studies offer considerable evidence on the barriers that rural dwellers face in accessing health care, however, less is known about perceptions of rural service providers (Brems et al., 2006). In a study exploring international perspectives on rural nursing, Bushy (2002) found that Australia, Canada and the USA all experienced similar problems around the retention, recruitment and education of rural health professionals whilst all faced increasing numbers of people who are described as vulnerable in rural areas. Of particular importance to rural mental health professionals were the implications in terms of rural lifestyle. For instance, in all three countries, it was found that high public visibility meant the boundaries between work life and private life were ‘nebulous and diffuse’; such informal social structures therefore represented a significant problem in terms of maintaining anonymity and confidentiality (Bushy 2002). Such international perspectives are important in order to assess whether context matters or whether the challenges are the same for rural professionals in other countries.
The issue of recruitment, retention and training of rural health workers is a perennial theme in the literature (Deaville 2003; Daniels et al., 2007; O’Toole et al., 2008; Moore et al., 2010). Brems et al. (2006) found that health professionals in rural areas often faced more challenges in delivering services than their urban counterparts. In particular, rural service providers experienced significant problems in terms of professional isolation and access to resources such as expertise and consultations. Other themes included confidentiality limitations, the burden of travel (particularly for mental health service providers), avoidance of care by patients and the overlapping roles experienced by healthcare professionals. A lack of separation between public and private life due to the close-knit nature of rural communities created an additional burden on professionals (another consideration is arguably the greater onerousness of having to make decisions as isolated professionals about depriving service users of their freedom, and all that that entails in terms of the service users own self-image and reputation within the local community).

In addition to common issues in developing an effective rural workforce, Moore and colleagues (2010) found issues specific to mental health professionals in Australia: the unattractive nature of mental health work, the fragmented administration of the system and inadequate training made it difficult for organisations to support personnel in ways that develop them professionally. Issues of leadership and how well rural mental health professionals are managed were also significant in terms of the retention and recruitment of staff. This thesis explores whether such issues are also faced by service providers in rural Scotland and rural Canada (Laurent 2002; NHS Scotland 2007).

2.4.1 Summary of Rural Service Providers

For rural service providers, recruitment and retention are prominent themes. The problems of how to recruit and retain health professionals is arguably linked to issues such as the overlap between the public and the private domain, along with concerns around professional isolation and training. The aforementioned study by Moore and colleagues was carried out in rural Australia, however, it is of interest to explore whether such issues are evident with mental health service providers in the current study given the evidence of cutbacks to public services highlighted in Chapter One. Moreover, given the challenge that rural culture can create in terms of help-seeking, it is of interest to explore how rural service providers in the current study address it. The thesis will therefore use the following research question in relation to service providers:
‘What are the challenges that service providers face in rural areas?

2.5 Recovery

This thesis is situated within the field of social policy. It therefore seeks to understand the policy landscape and any current trends, or emerging ideas, in relation to mental health. This is important in order to see what bearing that has for the lives of those the policies are intended for. Therefore, it is essential to outline recovery as it is the most significant policy paradigm that has emerged since deinstitutionalisation. It is a central feature of mental health policy globally (e.g. the Scottish Government’s 2006 *Delivering for Mental Health*; the Australian Government’s 2008 *National Mental Health Policy*; [England and Wales] (2009) *New Horizons*; and the Mental Health Commission of Canada’s 2009a *Towards Recovery and Wellbeing*) and arguably represents a ‘paradigm shift’ that entails changes in values and practices in mental health care.

The concept of recovery is widely attributed to the work of Harding and colleagues (1987) and their longitudinal study of schizophrenia. Their results challenged the dominant thinking around chronicity and severe mental illness at that time, offering the opportunity for a reconceptualization of mental illness based on the idea that other outcomes, rather than simply deterioration, were possible. Personal accounts of recovery have also contributed to this paradigm shift (Houghton 1982; Deegan 1988; Leete 1989). The convergence of both approaches invokes notions of clinical recovery as well as social recovery; ‘recovery from as well as recovery in’ (Davidson & Roe 2007, p. 459).

At the heart of recovery lie concepts relating to the importance of hope, gaining control, having a sense of self, and of finding meaning and value in life, for those who experience mental health problems (Anthony 1993; Deegan 1997; Spaniol & Gagne 1997; Smith 2000; Markowitz 2001; Carpenter 2002; Repper & Perkins 2003; Ramon et al., 2009; Tierney and Kane 2011; Mental Health Foundation 2013a). It suggests a ‘self-directed’ process rather than an end point (Deegan 2002) which is highly individual in nature (Ralph 2000; Onken et al., 2002; Smith-Merry et al., 2011). Other themes include the notion that both internal and external conditions are important in the recovery process (Ralph 2000; Jacobson & Greenley 2001; Ochocka et al., 2005). Thus, it focuses on strengths in spite of symptoms; contrasting to the biomedical model which is primarily deficit-based (see Figure 2) in its assumption that mental illness has an underlying biological cause, the removal of which will result in a return to health (Slade 2009a).
contrast, the personal recovery model encourages personal growth and the idea that the individual is not simply defined by their mental illness. The goal for recovery-orientated services then is to help the individual build a valuable and meaningful life which is not simply defined by their mental health status.
Figure 2: Goal of biomedical model versus recovery model

Biomedical Model (Clinical Recovery)

Goal – remission or removal of symptom
Outcome – return to health (pre-morbid functioning)

Deficit Based

Personal Recovery Model

Goal – striving and expectations
Positive Identity (amplifying strengths)
Responsibility (empowerment)
Outcome – integrated living

Strengths Based
(with focus on social outcomes)

Goal – helping to create valuable and meaningful lives for service users, even in the midst of mental health problems
However, recovery is highly individualistic which makes it less amenable to empirical study. A further complexity is that some individuals have learned to live with their mental health problems without any need to ‘recover’. The Hearing Voices Network (http://www.hearing-voices.org/voices-visions/), for example, encourages those who hear voices to talk about them and to learn and grow from them, but recognise that some may already be doing this without help, ‘Many people who hear voices simply don’t need to recover – they are already living lives that they love’ (Hearing Voices Network 2013).

Tepper et al. (2013) attempted to measure perceptions of recovery in terms of age (older adults versus younger adults, n-71) for participants involved in psychiatric rehabilitation programs in the US. They found that whilst age did not predispose someone to pessimistic thinking in terms of recovery, older adults tended to associate recovery with symptom reduction if their first psychiatric hospitalisation occurred prior to the emergence of the recovery movement. The authors conclude that recovery-orientated practice may be most effective for older adults when it recognises earlier treatment experiences and natural attention to symptom improvement. Such research highlights the way in which quantitative methodologies can inform and expand the knowledge base on recovery and its implementation.

Schwartz et al. (2013) sought to understand what matters in recovery from the perspective of service users and providers. For service users, this centred partly on feeling misunderstood, with the focus remaining on their symptoms rather than their experience. For service providers, intrapersonal conflict was noted between the ‘need to protect’ and the desire to support service user autonomy. This qualitative contribution by Schwartz et al. is important because it addresses the concept of recovery in an institutional setting, which remains lacking in the literature (excepting Davidson & Strauss 1992). It also incorporates the perspectives of both sides instead of an ‘either or’ approach.

Whilst some academics note the positive attitude of the evidence-based movement towards the concept of recovery (Torrey et al., 2005) there is also a growing literature around how it should be incorporated into service provision (Anthony 1993; Davidson et al., 2006; Piat et al., 2010; Chen et al, 2011). Key themes include the attitudes of service providers in relation to ‘recovery-orientated’ practice (Green et al., 2008; Cleary & Dowling 2009; Salgado et al., 2010; Smith-Merry et al., 2011), what the key characteristics for recovery-orientated services should be (Anthony 2000; Jacobson &
Greenley 2001) and the importance of service user perceptions in the process (Marshall et al., 2009; Ning 2010).

In addressing how recovery can be implemented in practice, Slade (2009b) divides the key differences between traditional mental health services and recovery-orientated ones as follows:

Table 1: Differences between traditional and recovery-orientated services (source Slade 2009b)

<table>
<thead>
<tr>
<th>Traditional approach</th>
<th>Recovery approach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Values and power arrangements</strong></td>
<td></td>
</tr>
<tr>
<td>(Apparently) value-free</td>
<td>Value-centred</td>
</tr>
<tr>
<td>Professional accountability</td>
<td>Personal responsibility</td>
</tr>
<tr>
<td>Control oriented</td>
<td>Oriented to choice</td>
</tr>
<tr>
<td>Power over people</td>
<td>Awakens people’s power</td>
</tr>
<tr>
<td><strong>Basic concepts</strong></td>
<td></td>
</tr>
<tr>
<td>Scientific</td>
<td>Humanistic</td>
</tr>
<tr>
<td><strong>Pathography</strong></td>
<td></td>
</tr>
<tr>
<td>Psychopathology</td>
<td>Distressing experience</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Personal meaning</td>
</tr>
<tr>
<td>Treatment</td>
<td>Growth and discovery</td>
</tr>
<tr>
<td>Staff and patients</td>
<td>Experts by training and experts by</td>
</tr>
<tr>
<td></td>
<td>experience</td>
</tr>
<tr>
<td><strong>Knowledge base</strong></td>
<td></td>
</tr>
<tr>
<td>Randomised controlled trials</td>
<td>Guiding narratives</td>
</tr>
<tr>
<td>Systematic reviews</td>
<td>Modelled on role models</td>
</tr>
<tr>
<td>Decontextualised</td>
<td>Within a social context</td>
</tr>
</tbody>
</table>
Working practices

<table>
<thead>
<tr>
<th>Description</th>
<th>Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on the disorder</td>
<td>Focus on the person</td>
</tr>
<tr>
<td>Illness-based</td>
<td>Strengths-based</td>
</tr>
<tr>
<td>Based on reducing adverse events</td>
<td>Based on hopes and dreams</td>
</tr>
<tr>
<td>Individual adapts to the programme</td>
<td>Provider adapts to the individual</td>
</tr>
<tr>
<td>Rewards passivity and compliance</td>
<td>Fosters empowerment</td>
</tr>
<tr>
<td>Expert care co-ordinators</td>
<td>Self-management</td>
</tr>
</tbody>
</table>

Goals of the service

<table>
<thead>
<tr>
<th>Anti-disease</th>
<th>Pro-health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bringing under control</td>
<td>Self-control</td>
</tr>
<tr>
<td>Compliance</td>
<td>Choice</td>
</tr>
<tr>
<td>Return to normal</td>
<td>Transformation</td>
</tr>
</tbody>
</table>

A significant point here is that, according to advocates, recovery models should replace the traditional ‘assessment-treatment-cure’ ideologies (Shepherd et al., 2008) and, therefore, should not add to the burden of over-stretched professionals. Arguably the concepts laid out by Slade (2009b) are important in terms of demonstrating clearly what recovery looks like in practice and how this differs from clinical preoccupations. However, despite its considerable influence at policy level, to date there is no universally accepted definition of recovery (Slade 2007). As a result, the term has often been used interchangeably to mean a variety of things including a model, a philosophy, an approach, a paradigm and a movement (Clearly & Dowling 2009; Smith-Merry et al., 2011) suggesting it is defined more by a shared set of beliefs or values than anything more specific. A commonly cited definition in the literature is provided by Anthony (1993):
Recovery is a deeply personal, unique process of changing one's attitudes, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful life even with the limitations imposed by disability. It involves developing new meaning and purpose in life as one grows beyond the catastrophic effects of illness/injury’ (p. 527).

Other definitions (that focus on the fluidity of recovery) are provided by Onken and colleagues (2007). After an analysis of elements and definitions of recovery in the literature, they conclude,

‘Recovery is multidimensional, fluid, nonsequential, complex, and permeates the life context of the individual with some elements linked primarily to the individual and others that are more deeply infused with the role of the community to provide resources and opportunities to individuals as they embark on a recovered journey’. (p. 10).

The American Psychiatric Association’s (APA) position statement on recovery (focusing on the clinical aspects) define it as,

‘The concept of recovery emphasises a person’s capacity to have hope and lead a meaningful life, and suggests that treatment can be guided by attention to life goals and ambitions. [The recovery approach] recognizes that patients often feel powerless or disenfranchised, that these feelings can interfere with initiation and maintenance of mental health and medical care, and that the best results come when patients feel that treatment decisions are made in ways that suit their cultural, spiritual, and personal ideals’ (APA 2005).

The literature highlights that the ‘recovery agenda’ has not been welcomed in all corners. Despite a sizeable literature, there remain concerns around the lack of consensus (Davidson et al., 2006a; Pilgrim 2009), the implications for already stretched mental health services (Davidson et al., 2006a; Shepherd et al., 2008); the quality of supporting arguments for recovery (Tilley & Cowan 2011); and how to implement recovery-orientated practice based on the current knowledge base (Davidson et al., 2006). Given its focus on individual choice, the concept can also potentially ignore the wider social and political contexts that have often served to restrict and exclude service users (Weisser et
Further understanding is required on the mediating factors in recovery and chronicity (Humphries et al., 2007). There is also limited research among stakeholder groups (Piat et al., 2010). Some academics also question how much focus should be given to symptoms versus strengths, and the primacy of the role of provider versus the service user in the helping process (Starnino 2009; Rudnick 2012b).

Roe and colleagues (2007) highlight the lack of critical engagement around conceptualising recovery as a process. In neglecting such a rigorous scientific analysis around what the process entails, it potentially runs the risk of the concept becoming meaningless in academic research (Rudnick 2012b). Finally, there are some concerns that the recovery agenda, with its promotion of self-management, may be used to justify the cutback of services (Humphries et al., 2007). Arguably, such concerns hinge on whether recovery is advocated as an alternative to more traditional treatment or as an ancillary process. In the Scottish Government’s ‘Delivering for Mental Health’ (2006a) it would appear that recovery-orientated services are specifically about ‘the degree to which services are structured to deliver better outcomes across a range of domains, including employment, housing, education and training opportunities, family and social life’ (p. 1), suggesting that they are not mutually exclusive; recovery appears to be envisioned here as an enhancement to existing models. Nevertheless, it remains to be seen whether recovery can be used as a way for a cost-cutting agenda.

However, the literature also shows first-hand accounts of hope and healing associated with recovery (Stocks 1995) and the importance of the lived experience of service users for informing a robust evidence-base (Ning 2010); suggesting that the recovery agenda brings with it an opportunity for new directions in approaches to mental health care. This is particularly useful and relevant for the current study given its aim of exploring the lived experience for service users who are located in remote and rural areas.

### 2.5.1 Summarising Recovery

The concept of recovery has emerged as a new approach to mental health care that challenges the dominant biomedical model currently used by western countries. In Scotland, it has become increasingly important in terms of mental health policy and practice. At its core it invokes notions such as hope, healing, empowerment and the right to a meaningful and valuable life for all those who experience mental health problems. Despite a lack of consensus in terms of its definition and how it should be operationalized, the literature demonstrates the importance it places on the lived
experience of service users; ensuring the knowledge base accurately reflects the subjective reality of mental illness. Additionally, its promotion of self-determination ensures policy and practice is aimed in the right direction to reflect greater recognition of the autonomy of the individual; service users are then increasingly conceived as active agents rather than passive recipients of care. Key issues, however, centre on the lack of critical engagement around conceptualising recovery as a process and how much focus should be given to symptoms versus strengths. Arguably this should be of central concern in terms of the knowledge base given its prominent position in mental health policy. (The current thesis addresses these concerns and provides a rigorous analysis of the process of recovery in Chapter 6). It is critical, therefore, to consider the concept of recovery when looking at data on rural mental health.

For the purposes of the current research, the following definition of recovery will be used:

Recovery is a deeply personal process of changing one's attitudes, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful life even with the limitations imposed by disability. It involves developing new meaning and purpose in life as one grows beyond the catastrophic effects of illness/injury (Anthony 1993).

2.6 The Voluntary Sector

Moving the loci of care from the asylum to the community has meant that there are a range of community-based services and supports for people who use mental health services. A key dimension for this thesis is the contribution of mental health voluntary organisations, given their importance in rural community life. It is, therefore, necessary to review the literature on the voluntary sector and the issues it currently faces, particularly in relation to health and rurality. The funding climate is important to highlight in order to understand more about the pressure such organisations are under.

The following section starts by outlining the role of the voluntary sector in policy development. Notable is the strong association with Third Sector discourse meaning that the two are often used interchangeably. The section will also look at the changing relationship between the state and voluntary sector organisations, key here is the emergence of a partnership approach between the two. Finally, the section will explore the contribution of the sector in relation to rural health.
2.6.1 Locating the voluntary sector

The process of deinstitutionalisation has meant there are now a number of agencies involved in providing care to those with mental health problems. In the UK, primary services are often the first point of contact for those requiring mental health provision. However, the voluntary sector (which forms part of the Third Sector) has played an increasingly prominent role in terms of service delivery. In the UK, the Third Sector is also referred to as the Non-Profit sector, the Non-Statutory sector, the Non-Government sector, and the Voluntary and Community sector.

The voluntary sector is playing an increasingly prominent role in delivering health and social care support in the UK. Underlying this trend has been the desire for cost effective care provision that is both flexible and responsive to the local needs of individuals who are experiencing mental and/or physical impairment (Milligan 2000). This shift has raised the profile of voluntary sector agencies as providers of health care services, and has also led to a significant change in the relationship between the state and the ‘not-for-profit’ sector.

The relationship between the voluntary sector and the state has a long and complex history (Milligan 1998; Alcock 2009). The importance of the voluntary-statutory relationship has been observed by a number of commentators (Graycar 1983; Morison 2000; Smith & Oppenheimer 2005; Milligan et al., 2008) of particular interest has been the transfer of resources from the state to the voluntary sector (National Council for Voluntary Organisations 2013). Moreover, the policy to promote and support voluntary/third sector activity is noticeably distinct between each nation-state, with Scotland promoting the sector primarily through local government in contrast to England where it occupies a central position in policy (Alcock 2009).

Lewis (1999) explores the historical and socio-political dimensions of this relationship, emphasizing the paradigm shifts that have occurred since the nineteenth century. Whilst the voluntary sector has always sought a ‘partnership’ approach with the state, its nature in terms of funding, terms and conditions and the associated expectations of each

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6 In Scotland, the ‘Community Development Programme’ has been used as a strategy for promoting inclusion and for building sustainable communities. In particular, the Scottish Community Development Centre (SCDC) works with a number of local projects around Scotland as a way of encouraging community participation.
government have changed significantly over time. Understanding these socio-political dimensions from an historical perspective has, according to Lewis, been ‘conspicuously absent on the part of the government’ (p. 256). The prominent role for voluntary sector organisations in delivering health and social care stems largely from the neo-liberal agenda of earlier Conservative Governments in the 1980s and their introduction of market-based principles to local welfare service delivery, which was largely continued under New Labour (Milligan & Fyfe 2004), leading to national compacts between representatives of the voluntary sector and the state. Such developments are also noted internationally, for example Mitchell (2001) highlights this neo-liberal agenda in Canada and the increasing scope and power of those voluntary organisations that are located between the state and society. Such organisations were coined by Wolch (1990) as ‘shadow state’ institutions to describe those voluntary sector organisations which have responsibility for delivering services previously provided by the state, outside of traditional democratic controls, but also remaining controlled both formally and informally by it (para-state apparatus).

The growing political and social significance of the voluntary sector is highlighted by the coalition governments’ renewed focus on all things local, calling for the voluntary sector to play an increasingly bigger role in designing and delivering public services (National Council for Voluntary Organisations 2013) linked to increasing cutbacks in public health services. However, such organisations are under considerable pressure due to increased competition in health services. The National Health Service (NHS) policy reforms (for Scotland, England and Wales), reintroducing market principles into the public health sector (albeit regulated), are intended as a way of improving quality and innovation. Nevertheless, funding expenditure in relation to mental health is primarily focused on inpatient services, at the expense of community services (despite a policy emphasis on early intervention and building the capacity of community support) (Balakrishna 2007), again reflecting the gap between the government’s expressed aspirations and the realities of policy implementation. Indeed, this contradictory emphasis on reducing public expenditure and on promoting ‘the Big Society’ raises questions about the integrity of government policy and its real view of the voluntary sector.

There can be considerable implications for the restructuring of the statutory sector role in health and social care delivery. Work by Milligan (1998) that focused on voluntary organisations in Scotland (in both rural and urban locations) found that the contract culture favoured certain types of behaviour (e.g. service provision) over others such as
advocacy, despite the importance of the latter for providing an effective voice for those who need it. Some of the organisations had also been requested by local authorities to take on the provision of tasks not previously within their remit, suggesting there may be implications in terms of the fundamental premise on which such organisations are founded. In terms of the rural organisations in the study, time and distance were distinct difficulties with regard to voluntarism, leading to the conclusion that the restructuring of health and social care delivery can lead to the growth of geographical inequity in community-based service provision.

There are limitations in empirical knowledge and understanding of the voluntary/third sector. As Alcock (2009) suggests, ‘there is no consistent and undisputed data source on the size and shape of the sector…’ (p. 4). Such limited knowledge is noted in relation to the rural voluntary sector (SCVO 2003). Wigglesworth and Kendall (2000) suggest much of the data cannot demonstrate the important role the sector plays or the impact it has on communities. In response to this knowledge gap, the Scottish Government recently commissioned a review of the literature on the third sector (to which the voluntary sector belongs) in rural Scotland (Woolvin 2012). The review highlighted ‘….there may be a distinct role for the third sector in rural areas in the provision of services given the distinct socio-economic and spatial characteristics of more rural areas’ (Woolvin 2012, p. 2). The National Council for Voluntary Organisations, however, has gone some way to address the limitations in knowledge with the publication of its UK Civil Society Almanac, detailing facts and figures on the size and scope of the sector.

2.6.2 Partnership and Funding

The voluntary sector now receives a significant amount of investment from government (Clark et al., 2009) causing some to question whether it creates barriers between voluntary organisations and the community groups they serve (Wolch 1999) or allows non-profit organisations to still objectively serve the interests of communities (see Milligan 1998; Fyfe & Milligan 2003b; Osborn & McLaughlin 2004). Many voluntary organisations now draw on best practices from the for-profit business world (Landsberg, 2004) including business management techniques (Trudeau 2008) and employing staff with professional credentials (Austin 2003). For some, the impact of business practice on the non-profit sector undermines its culture and mission (Trudeau 2008) which ultimately can endanger it (Young 2002).
The literature suggests that the boundaries between the government and the voluntary sector are blurring because of an increasing emphasis on partnership between the two (Clark et al., 2009). According to proponents, the partnership approach not only raises the profile of the voluntary sector but allows the government and non-profit organisations to work in ways that promote more inclusive policymaking and meet the needs of the public, essentially benefiting both sides (Ospina et al., 2002). The partnership approach also provides a way of delivering services in a cost-effective manner through the pooling of resources (Lowndes & Skelcher 1998).

However, whilst the flexibility of the partnership approach allows for the resolution of complex policy problems, some suggest the ‘contract culture’ calls into question the very independence of charitable societies (Prochaska 2005; Panel on the Independence of the Voluntary Sector 2012). Clark et al. (2010) also point out that, whilst statutory funding is integral to the voluntary sector, it represents a tiny proportion of public expenditure (2.2%), thereby illustrating the inequality of power between the two sides. Some have also suggested the partnership approach fails in its inclusive premise, with state actors playing a dominant role with only a weak voluntary and community sector involvement (Davies 2002). The creation of partnerships can also produce partnership fatigue and low levels of community interest (Bristow et al., 2009).

2.6.3 Voluntary Sector and Mental Health

Voluntary organisations play a pivotal role in supporting mental health service users in the community, from providing supported housing opportunities, training and employment assistance, advocacy services, drop-in centres and day-care services. Through their close networks with communities they can often provide services in a way that government finds difficult due to its bureaucratic structure (Bubb 2006; Haugh & Kitson 2007).

Research highlights that voluntary organisations delivering community-based mental health services often provide value for money and go beyond the traditional spectrum of health and social care services by delivering a broader range of support (Unllais undated). They also have the ability to offer choice and respond flexibly (Bristow et al., 2009), and to provide knowledge and expertise to meet complex personal needs (Woolvin 2013) and to help service users to overcome experiences of marginalisation and exclusion from mainstream society (Milligan 2000).
Matthew (2001) found that they promoted empowerment for members, both at an individual level (psychological empowerment) and a community level (community empowerment). Malpas and Weekes (2001) also identified a range of benefits for members using voluntary drop-ins, from alleviating loneliness, to instilling motivation in terms of continuing to engage with the group (this has resonance with the discussion in Chapter Six of this thesis). Neither of these studies, however, had a rural dimension to them leading to questions around whether such contributions are discernible within other, i.e. rural, contexts. Furthermore, both studies focused specifically on the benefits within these groups leading to questions about the extent to which they act as a ‘bridge’ to involvement in group activities outwith the organisations (see Chapter 7). As previously mentioned, some writers have suggested that ‘drop-in’ centres inadvertently bracket-off participants from the wider community ensuring networks are limited to other service users.

In her research on mental health voluntary groups in Scotland, Milligan (2000) demonstrates some of the challenges and constraints facing such organisations and the amount/type of support they can provide, (largely dependent on the priorities and patterns of local authority spending). Such research presents a challenging climate for voluntary organisations. A further dimension is the on-going welfare reforms and consequent cutbacks to public health by the current coalition government, which has arguably put even more pressure on voluntary organisations.

2.6.4 Rurality and Key Policy Initiatives

In Scotland, the non-profit sector is said to make an important contribution in helping to deal with problems of exclusion (Scottish Government 2009b). While there is a greater focus in the literature on more populous areas (Dacome & Bach 2009), the sector plays an important role in the Highlands of Scotland (Highlands and Islands Enterprise 2002). In terms of legislation, the Local Government in Scotland Act (2003) established a statutory basis for Community Planning in Scotland, placing a duty on local authorities to lead and facilitate community planning in their areas (Scottish Executive 2004). Most notably, it required the commitment and participation from public, private and voluntary sector bodies in order to better serve communities. In addition, Community Health Partnerships have been established by NHS Boards in order to facilitate effective partnership working and a more integrative approach for services, encouraging a more prominent role for the voluntary sector.
At a national level, the Scottish Government (2011c) has set out a range of national outcomes to help create a ‘healthy, flourishing country’ (as part of the National Performance Framework). At a local level, this requires local authorities to commit to the Single Outcome Agreement (SOA) in order to help meet those outcomes. In the Highlands, the SOA is an agreement between the Scottish Government and the Highland Community Planning Partnership (HCPP) that sets out how public agencies in the Highlands work together to contribute to the national outcomes. In terms of the voluntary sector, NHS Highland and the Highland Council together contribute over £15m a year to voluntary and community groups (Highland Council 2009b). Given the current statistics on mental health in the Highlands (see Chapter 1), however, such financial support to voluntary organisations is essential.

Whilst investment in the voluntary sector is important, there remain considerable challenges in the context of rurality. Qualitative research by EKOS Ltd (2009) found that rural areas of Scotland had been exposed to significant centralisation of public and voluntary sector services, which had resulted in a loss of vital services to distant locations. Consequently, the high cost and lack of availability of public transport had restricted opportunities for individuals to access a range of services and supports. For those with mental health problems, rural areas were less frequently served by support organisations due to geographical distance and availability of volunteers/staff, increasing the risk of isolation and loneliness. A further dimension was that rural service users often faced poverty, making it harder for them to engage with services. To compound this situation, many felt embarrassed about both their mental health and poverty status and, therefore, did not wish for their problems to become known to the local community (EKOS 2009).

2.6.5 Summarising the Voluntary Sector

The voluntary sector has occupied a prominent position in health and social care delivery, particularly since the 1980s. From the literature, it can be seen that there is general agreement of the significant and wide-reaching impact of voluntary organisations: they not only build trust with those who use their services but can also respond in a flexible manner. Given the policy imperative towards social inclusion, such organisations can help service users overcome experiences of marginalisation and exclusion from mainstream society (Milligan 2000). However, the knowledge base remains limited on the voluntary sector in rural areas (SCVO 2003); underlining the need for further study of
the role that such organisations play in the mental health landscape and their impact for remote and rural service users.

This thesis will address these gaps in knowledge by looking at the benefits of membership to mental health voluntary organisations and by exploring whether such organisations offer something that other community-based mental health services do not:

‘What benefits are there for service users attending voluntary groups in remote and rural areas?’

‘Do voluntary groups offer something that other rural mental health services do not?’

2.7 Social Capital

The centrality of localism within current policy thinking has brought increasing attention to strategies that build sustainable communities. As such, there has been an on-going interest with the concept of social capital (Shirani 2011). Specifically, under the coalition government, the idea of building strong and active communities is captured in its ‘Big Society’ discourse, centred around the premise of devolving power away from a smaller state and building a ‘Big Society’ where localism and individual responsibility combine to create a ‘Better Britain’ (Westwood 2011). In the context of mental health policy, the concept has been used as a way of reducing the incidence of mental illness by promoting social cohesion and building community capacity (see ‘No health without mental health: A cross-Government mental health outcomes strategy for people of all ages’ Department of Health 2011a; Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011 Scottish Government 2009a). However, given the on-going evidence of social exclusion for mental health service users (Mental Health Foundation 2013b), it is arguable that attempts to foster social cohesion have not been entirely successful. Given its interest at policy level, this thesis uses social capital to critically engage with the data. In order to use it as an interpretative theory, the following discussion will now consider how it has been framed, who the main theorists are, its link to (mental) health and what role it plays in rural community life.
2.7.1 Defining Social Capital

The concept of social capital finds its origins in sociology and political science. In those fields it has been used to describe the resources available to individuals through their affiliative behaviours and membership in community networks (Kawachi 2006).

The literature reflects that social capital is a complex construct that has suffered from the same problems of conceptualization as social exclusion/inclusion. Whilst it has been used by a variety of disciplines as disparate as sociology and agriculture (Wood & Giles-Corti 2008), its precise meaning and how it can be measured are significant issues.

The Organisation for Economic Co-operation and Development (OECD) defines social capital as:

‘networks together with shared norms, values and understandings that facilitate cooperation within or among groups’ (2012, p. 103)

However the World Bank (2012) adds a further element to this and suggests:

‘Social capital refers to the institutions, relationships, and norms that shape the quality and quantity of a society's social interactions…Social capital is not just the sum of the institutions which underpin a society – it is the glue that holds them together’

The idea of ‘glue’ that holds society together is also shared by other authors (Potapchuk et al., 1997; McKenzie et al., 2002; Altschuler et al., 2004; Hsieh 2008). For some, social capital is seen as the features of social organisation, such as civic participation, norms of reciprocity, and trust in others that facilitate cooperation for mutual benefit (Kawachi & Berkman 2001; Cullen & Whiteford 2001). Whilst for others, social capital can ‘boost productivity and incomes’. Interpreted in this way social relationships can influence individual behaviour and affect economic growth. Social capital is then explicitly linked to economic growth (Pennar 1997). Underlying such definitions is the idea that social capital refers to features of social relations.

At a government level, social capital has generated a significant amount of interest and has been incorporated into a wide range of public health and community agendas and initiatives, given the economic and social benefits it can bring to a society (Lynch et al., 2000; Wood & Giles-Corti 2008). The concept suggests that the quality of social
interactions can improve health and be an important tool for successful community development (Scottish Council for Voluntary Organisations 2003).

Theoretical exploration of social capital has identified three main dimensions:

- **structural/cognitive** - the networks, associations and institutions that link people and groups together
- **bonding/bridging** - whereby ‘bonding’ is inward-focused and characterised by strong norms and loyalty and ‘bridging’ is outward-focused on links with different groups
- **horizontal/vertical** - whereby horizontal describes social capital between people in similar strata of society and vertical describes the integration of people in different strata (McKenzie & Harpham 2006).

According to Putnam (see section 2.7.4) of all the dimensions along which forms of social capital vary, the most important is the distinction between bridging and bonding (Putnam 2000, p. 22). The current thesis also aligns itself with this distinction and uses bonding and bridging as the focus for exploring social capital.

### 2.7.2 Key Theorists

The literature suggests that social capital involves social networks, citizenship, trust, norms of reciprocity and connections among individuals, although different definitions place varying emphasis on each of these factors. Despite such variances, the literature highlights two distinct schools of thought in social capital discourse: political scientist Robert Putnam’s (1993a) *communitarian* approach and Pierre Bourdieu’s social theory of forms of capital (1986).

#### 2.7.3 Pierre Bourdieu

In ‘The Forms of Capital’ (1986) Bourdieu separates capital into three components: economic, cultural and social, to account for the structure and functioning of the social world.

Social capital for Bourdieu is defined as ‘the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition - or in other words, to membership of a group – which provides each of its members with the backing
of the collectivity-owned capital, a ‘credential’ which entitles them to credit, in the various senses of the word’ (Bourdieu 1986). Such relationships, and the obligations they confer, can exist in the practical state and/or in symbolic exchanges. The concentration of social capital into networks and groups ensures there are both material profits for members, for example access to various services that arise from useful relationships, and symbolic profits such as the benefits of association with prestigious groups. According to Bourdieu, the existence of a network of connections is the product of investment strategies that are specifically aimed at establishing lasting, useful relationships. In order to make either social or cultural capital useful and profitable, however, the investment of time and energy are the greatest components needed. For example, whilst economic capital can provide immediate access to some goods and services, others require the addition of social capital (or cultural capital) in order to gain access.

For Bourdieu, social capital offers a way of understanding the unequal distribution of power in society by the way in which class structures are maintained and reproduced (Baum & Palmer 2002). Essentially, social capital is conceived as being the property of an individual: a person’s individual social relationships facilitate unequal access to goods and services, and it is these relationships that define social capital (McKenzie & Harpham 2006, p. 13).

2.7.4 Robert Putnam

In contrast to Bourdieu’s individual-level analysis of social capital, the influential work of Robert Putnam regards social capital as the property of groups. In Making Democracy Work (1993a) Putnam carried out empirical work on the performance of regional governments in Italy. His thesis focused on the notion that the success or failure of each regional government was directly related to levels of civic engagement and subsequently levels of social capital. The regions with successful government were found to be the ones with strong traditions of civic engagement, they therefore had high levels of social capital.

In his later work Bowling Alone (2000) Putnam is more cautionary, setting out key factors that have impacted on civic disintegration in America. The changing family structure has, according to Putnam, left the average American citizen with less leisure time to be involved in civic life. Additionally, the arrival of electronic entertainment has meant people are more inclined to spend leisure time at home: not only leading to less civic
engagement, but also less family engagement, as watching television, for example, becomes increasingly a solo act.

For Putnam, social capital is an important component of a strong civil society; entailing mutual obligation and responsibility for action. Underlying his conceptualisation is that social networks of community engagement help to foster norms of generalised reciprocity which can facilitate cooperation for mutual benefit. Moreover, the quality of reciprocal relations helps to build trustworthiness amongst community members which ‘lubricates social life’. In addition, the benefits of social connections are not just for the individual, they can also be felt at a community level. Thus, social capital is both a private and public good. For example, people who are well-connected, in a well-connected society, are more productive than people who are not well-connected. Nevertheless, even those who are not as well connected may still feel the benefits if they live in communities which are (Putnam 2000).

For Putnam, there are five principal characteristics of social capital:

1. Community networks, voluntary, state, personal networks
2. Civic engagement, participation, and use of civic networks
3. Local civic identity – sense of belonging, solidarity, and equality with other members
4. Reciprocity and norms of cooperation, a sense of obligation to help others, and confidence in return of assistance
5. Trust in the community

Whilst Putnam’s theory has made it one of the most commonly used definitions, it has been challenged by a number of writers who suggest that earlier approaches to social capital are more useful (Pevalin 2003; Webber & Huxley 2004). Putnam’s communitarianism has also been criticised for ignoring the wider global political economy and its contribution to the decline of community (Defilippis et al., 2006). In addition, his interpretation of Italian civic institutions is criticised for their portrayal as ‘paragons of civic republicanism’, when in fact many produced elitist oligarchies that were constantly engaged in territorial wars (Tarrow 1996). Finally, whilst Putnam emphasises the integrative functions of voluntary associations and their contribution to civic life, he does not discuss the issue of conflicts between such organisations, or the power relations that are inherent to such organisations (Siisiäinen 2000).
Whilst both frameworks have enriched theoretical understanding of social capital, it has meant the concept remains ambiguous (Falzer 2007) and the literature divided between whether social capital is the property of individuals or the property of groups. The lack of conceptual precision has allowed researchers to select from a variety of definitions thereby weakening its potential as a concept for policy making (Almedom 2005; De Silva 2006). In addition, for an individual-level analysis, it is unclear where more traditional concepts such as social support and social networks end and social capital begins (McKenzie & Harpham 2006, p. 13).

A key thread running throughout this thesis is the role of rurality and its impact on the experience of mental health service users. As noted above, Putnam’s analysis incorporates civic identity and trust in the community as part of its conceptualisation. In this way, environment and the role of place is considered an important factor in social life. Additionally, Putnam’s emphasis on the importance of voluntary associations and their potential in fostering norms of reciprocity suggest that his theory is particularly suited to the aims and objectives of this study.

2.7.5 Social Capital and Mental Health

Research on the association between the social environment and health is extensive (Berkman & Syme 1979; House et al., 1982; Ostergren et al., 1991; Bergman 1995; Kawachi et al., 1996; Seeman 1996; Kawachi et al., 1999; Lennartsson 1999; Berkman et al., 2000; Lochner et al., 2003; Schneider et al., 2009). Some of the earliest work on the subject is within Durkheim’s study of suicide rates in Europe (Durkheim 1951) that hypothesises a direct relationship between social disintegration and suicide. Social cohesion could therefore be an antidote to anomie (Portes 2000) and could act as a buffer against the effects of modernization.

More recently the link between social capital and health has been established (Hawe & Shiell 2000; Putnam 2001). Mortality rates for people with few social relationships have been shown to be many times higher than those with larger social networks (Mckenzie & Harpham 2006, p. 13). In terms of mental health, levels of social capital have increasingly been shown to influence wellbeing and self-esteem (Scheufele & Shah 2000), lead to greater functional ability (Goldberg et al., 2003) and less inpatient service use (Roick et al., 2004). Mason et al. (2009) also highlight the role that the social environment places in adolescent depression.
Good social relations, such as friendship and social support, can not only act as a buffer against stress, but can also protect against a variety of illnesses (MacKenzie & Harpham, 2006, p. 7). Theoretical explanation of this can be drawn from the main effect and the stress-buffering models proposed by Cohen and Wills (1985) (see Figure 3). From this perspective, stress arises when an individual appraises a situation as threatening but lacks the appropriate coping responses. Social support can, therefore, be beneficial because social networks provide individuals with regular positive experiences and a set of socially rewarded roles in the community. This can contribute to wellbeing because it provides positive affect, a sense of predictability and stability, and a recognition of self-worth. Such forms of social support consequently act as a stress-buffering mechanism and play a role at specific points in the causal chain linking stress to illness.

The relationship between social capital and mental health is complex and multidimensional (Thomas 2006). The debate around what social capital is and how to define it consequently results in further problems for how it can be measured and assessed in relation to its links with mental health. The disparity of views on social capital has also hampered efforts to substantiate its link with health (Falzer 2007), and, by implication, mental health. Additionally, most of the studies with a clear objective to measure social capital have been in developed countries (Harpham et al., 2002). In general, qualitative assessments of social capital are limited and there has been a lack of primary data to investigate associations between social capital and mental health (Almedom 2005).
Nevertheless, after a systematic review of the literature, De Silva and associates (2005) concluded that there is some evidence connecting social capital and mental health. The authors reviewed 21 studies on social capital (14 at an individual level and 7 at an ecological level) and found that, at an individual level, there was strong evidence of an inverse association between cognitive social capital and common mental disorders. However, the results were rather mixed for the ecological studies: two showed inverse associations between measures of social capital and mental illness (cognitive compared with psychosis and combined compared with suicide), two positive associations (structural compared with suicide and combined compared with substance misuse) and 10 found no association. The authors conclude that the diversity in methodology, populations investigated and mental illness outcomes for the ecological studies make comparison difficult.

Interestingly, this review found contradictory results in two longitudinal studies from the USA. One study found high levels of social capital were associated with a decreased risk of suicide in discharged veterans (Desai et al., 2005), whilst the other showed that homeless mentally ill patients who lived in areas with high social capital had lower rates of recovery from alcohol dependence (Rosenheck et al., 2001). One possible explanation, the authors conclude, is that homeless mentally ill may potentially be stigmatised more readily than veterans, who may be considered more deserving of

![Diagram of social support and stressful events](source: Cohen & Wills 1985)
community support. Such findings are important as they not only highlight the complex nature of social capital, but that it may be context-specific.

The importance of context is also highlighted by Glendinning and West (2007) who found that Siberian rural dwellers experienced more positive mental health than their urban counterparts. In rural areas, social capital associated with family support and kin-based networks were important resources that facilitated positive mental health. However, the impact of social capital on rural populations remains underrepresented in the literature (De Silva et al. 2005).

There has been a lack of research into social capital and mental health (McKenzie et al., 2002). A major criticism of existing studies is that they vary in their methodological approach and are based on questions not originally designed to measure social capital (De Silva 2006; Haynes 2009). In addressing these concerns, a review by De Silva (2006) focused explicitly on published quantitative studies and how they have conceptualised and measured the association between social capital and mental health. Mental health outcomes were specifically focused on formally recognised indicators such as psychosis, suicide and common mental disorders. The findings represent a mixed picture: whilst some studies make clear at which level they were measuring social capital (i.e. ecological or individual), some did not; others that use Putnam’s theory, which is ecological, tended to measure social capital at the individual level. Such diversity, according to De Silva, has created more confusion than clarity. Also noticeable is an overrepresentation of urban studies in the review: of 28 papers reviewed, only one had a rural focus.

In relation to measurability, work by Wilkinson & Pickett (2010) is relevant. Collating data from the World Health Organisation’s mental health surveys, the authors have shown that different societies have very different levels of mental illness, with more unequal countries having noticeably higher levels (in some countries 5% of the adult population suffer from mental illness compared to the USA which reaches more than 25%). In the context of social capital, the link between mental illness and inequality is in terms of lack of social cohesion, lower levels of mutual trust and weaker community life. According to the authors, such a breakdown in social cohesion is strongly correlated with specific diagnoses such as anxiety disorders and impulse-control disorders.
2.7.6 Social capital in rural areas

There can often be unique challenges associated with the development of social capital in rural areas given the geographical context:

‘…greater distances, disbursed populations, smaller settlements, extended travel times and associated transport issues which characterise rural areas, can all have specific impacts on the development of social capital […] Rural isolation limits both access to key services and the capacity to develop and maintain social links and networks’ (National Council for Voluntary Organisations 2003, p. 25).

However, the informal sharing of transport can be commonplace for those in isolated rural communities. Thus, strong intra-community ties (local social capital) can confer mobility to those without access to privately owned transport in rural areas, essentially overcoming some of the challenges of social exclusion noted above (see Gray et al., 2006). Moreover, bridging ties between diverse interests has been important for preserving rural landscapes and for helping land workers such as farmers deal with the growing social diversity and an increasing integration with urban areas (Warner et al., 1997).

The idea of networks and reciprocal social relations is arguably highly salient in rural areas, which have often been associated with traditional collectivist values of hard work and cooperation, and a focus on family and community-orientated life (Martinez-Brawley 1990; Hirsch 2006). The notion of strong social ties is captured by the Countryside Agency and their work with rural communities (1999, cited by the National Council for Voluntary Organisations 2003):

‘The perceived strength of the community is one of the most prized features of rural life, and an asset that is largely seen to have been lost in urban areas’ (p. 24).

Nevertheless, just as community networks enhance a person’s sense of meaning, belonging and social support, they also demand a greater degree of conformity. Martinez-Brawley (1990), for example, notes the way in which businesses such as post offices have been ‘notoriously accurate barometers of the heartbeat and connectedness of communities’ (p. 38): they have been centres through which individual members become
known and connected to their respective communities. Yet these ‘identity-givers’ can demand loyalty and unqualified support from community members, citing an example where local residents mobilised against a proposed plan to move the location of a local post office by donating their own money to stop it.

Whilst a strong sense of community identity is perceived to be a strength of rural areas, there is a sense that the parochial ways of small communities (exemplified by the prevalence of extended informal networks) can be supportive or rejecting (see section 2.3.7). Some academics relate this to the ‘insider outsider’ dichotomy, or the way in which boundaries of community and belonging are negotiated and defined (Day & Murdoch 1993; Derounian 1998; Burnett 1998). This is arguably about how well people are connected within local networks, given that rejecting also occurs within them, particularly for those who are perceived as ‘different’ (see Parr et al., 2004). Informal social ties and networks are central for belonging and for personal/community identity; they give people a sense of who they are and where they belong (McAlister et al. 2010).

Bonded networks of family and friends (informal networks), and the importance of reciprocity within those networks can be important resources for rural dwellers to draw on (e.g. help with finding a job, giving emotional support or providing childcare). In differentiating between informal and formal rural networks, research by Brook Lyndhurst (2010) presents a more detailed and complex picture. The preference for some rural dwellers in the study was to only draw on their informal networks, and connect with other community members through, for example, the local pub (construed by some as the centre of community social life in terms of facilitating social networks). Others attributed a great deal of importance to the formal structures of community life (i.e. formal community and governance networks) and made a concerted effort to get involved. Whilst for others, their social networks were predominantly located outside the community in which they lived, preferring to keep an element of social distance with those in their immediate vicinity.

Interestingly, and particularly salient in the context of mental health, some participants in the study carried out Brook Lyndhurst (2010) noted the oppressive homogenous rural culture that prevented them from being themselves, ‘the cliquiness’, leading to their withdrawal from local social life. However, despite their outsider status, these participants were still positive about the rural communities in which they lived, noting the importance of the open space as a key determinant to their quality of life (in some cases they had specifically chosen to live and remain in those places despite not feeling
The study by Brook Lyndhurst is an important contribution given that the literature remains limited in terms of in-depth accounts of how social capital operates in rural areas.

2.7.7 Disadvantages of Social Capital

There is a sense from much of the literature on social capital that it is good, evoking notions such as ‘community spirit’ or ‘the collective good’. However, the implications of social capital for mental health are not always positive. Social exclusion, community conflict and political extremism can result from groups with exclusive membership (Moseley & Pahl 2007). Additionally, there can be an imposition of uniformity (Hewitt de Alcántara 1994) which can lead to a culture of cliquiness and suspicion (McKenzie & Harpham 2006). In relation to health, greater social integration, if accompanied by interpersonal conflict, can have a negative impact (Seeman 1996).

In terms of mental health, highly bonded communities may have little tolerance for those suffering from mental health problems, as McKenzie (2006) suggests, ‘rather than help these people, highly bonded communities may seek to exclude them, they may believe that such people may promote negative health norms and may be burdensome’ (p. 33). There is evidence that social networks may be more harmful than helpful for women with low resources and can exacerbate mental health problems (Kawachi & Berkman 2001).

In their comparative study of five communities in Australia Onyx and Bullen (2000) found that social capital was higher in rural areas in terms of factors such as ‘participation in the local community’ and ‘feelings of trust and safety’. However, urban areas scored higher in terms of factors such as ‘social agency’ and ‘tolerance of diversity’. These findings suggest that whilst rural communities may generate considerable bonding social capital (i.e. through strong mutual support) and high levels of civic participation, such support may not be extended to minority groups within the local area (Onyx & Bullen 2000).

Such findings suggest a complex picture for social capital in the context of rural mental health with a sense that strong social ties can regulate behaviour and, in some instances, be repressive. In his study of religion on the Island of Lewis in the Western Isles of Scotland, MacRitchie (1994) highlights the way in which the doctrine of Calvinism has created a strictly moralistic ‘insider outsider’ framing of social life; those who subscribe to that faith (and are consequently members of the church) and those who do not. The
heavy moralistic tone that pervades this particular form of religious belief not only places strict expectations on adherents (both in their inner subjective worlds and externally in terms of their behaviours) but also represses cultural expressions, creating a powerful disconnect with the islands' historical Celtic roots. This may be particularly felt by women, given, as MacRitchie notes, the relatively high numbers of female church members who become depressed (otherwise known as ‘Highland Twilight’), which he attributes to the profound sense of guilt which permeates the Calvinistic faith and to the divorcing of church from culture; these essentially deny women the pleasure to enjoy a cultural heritage rich in music, dance, poetry and song.

However, Voss (1996) presents a different and rather optimistic role for the church in relation to mental health from a rural American perspective. Specifically, according to Voss, the church has the potential to network and collaborate with other community bodies and professionals in a way that can lead to greater education, prevention and enrichment for rural service users, given the limited availability of services elsewhere. Such findings on the considerable role of the church in contributing and building social capital is also found with research by Olney and Burton (2011) and their study of one rural village community in England.

These contrasting examples suggest a further dimension of religious/ideological belief systems in relation to mental health/illness. A number of studies have pointed to much higher historical and contemporary rates of suicide amongst Protestants than amongst Catholics (Durkheim 1951; Becker & Woessmann 2011; Torgler & Schaltegger 2012). These studies emphasise the intrinsic characteristics of the two belief systems in relation to differences in suicide rates. In particular, differences in the institutional practices of each faith and their respective biases towards individualism (Protestantism) and communitarianism (Catholicism) are noted.

2.7.8 Section Summary

It can be seen that a problem lies in the lack of conceptual precision around defining social capital. At an individual-level, it is unclear where traditional concepts such as social networks end and social capital begins. The major division appears to be whether it is the property of individuals or the property of groups. Such division has been notably influenced by the academic contributions of Putnam and Bourdieu. According to Putnam, social capital is a resource of groups; it emerges as a result of social connections between people. It also brings with it individual benefits, in this way it is both a public
and a private good. In terms of the current thesis, a key aim is to understand the benefits of membership to voluntary groups (linked with wider policy initiatives in Scotland aimed at building healthy connected communities to reduce the incidence of mental health problems). His incorporation of both levels (i.e. individual and ecological) in his analysis of social capital therefore has resonance with the current study. As such, the study will align itself with Putnam’s theoretical exposition.

It is arguable that group membership and access to networks can potentially have a downside (Kawachi & Berkman (2001); Osborne et al. (2009)). In terms of empirical research, it is important that these are flagged so as not to presume that membership to groups are ‘necessarily good for one’s health’. Putnam (2001) also highlights the potential for negative externalities using the example of Oklahoma bomber, Timothy McVeigh, and his network of accomplices; being connected in this way allowed McVeigh to use social capital for destructive ends. Nevertheless, such examples are rare, in the vast majority of cases, there is evidence of powerful health effects of social connectedness (Putnam 2001).

Whilst the literature on social capital and mental health is growing, there is a gap in terms of what impact social capital has on service users. It is unclear how, or indeed if, social capital encourages better help-seeking pathways or better mental health outcomes (i.e. what contribution can social capital play in terms of service delivery?). As previously noted, social capital has been promoted by governments as a resource to reduce social exclusion and stigma but the knowledge base remains limited on how exactly this occurs and what mechanisms should be used to achieve this. There is also a very clear and significant gap in terms of the contribution of social capital to mental health within a rural setting (excepting Brook Lyndhurst 2010).

Continued research into social capital, therefore, has the potential to inform a robust evidence base around the promotion and prevention of mental illness at a policy level: moreover, its use as an analytical concept is valuable and important given the strategy to build sustainable communities. As De Silva and colleagues (2005) suggest, given the wide variations in rates of mental illness between geographical areas, there is a need to investigate the social and environmental causes. Further exploration of the links between social capital and mental health, and exactly how social capital can improve mental health outcomes (particularly for those living in rural areas) is, therefore, critical.

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7 The evidence highlighted in Chapter 1 of this thesis, suggests that there are considerable urban and rural differences in relation to suicide, with the Highland rate (0.08%) four times the national rate (0.02%)
Examining this relationship is essential to advance theoretical understanding of social capital and assess its usefulness for health services research (Derose & Varda 2009).

Given the on-going issue of stigma in relation to rural mental health, coupled with the challenges of availability and accessibility of mental health services, further work is necessary to explore whether social capital can help in ameliorating these challenges:

‘Is social capital useful in understanding the benefits and role of voluntary groups in a rural setting?’

The current study will adopt Putnam’s definition of social capital as:

‘the connections among individuals – social networks and the norms of reciprocity and trustworthiness that arise from them (Putnam 2000, p. 19).

The five principal characteristics of social capital are as follows:

- Community networks, voluntary, state, personal networks
- Civic engagement, participation, and use of civic networks
- Local civic identity – sense of belonging, solidarity, and equality with other members
- Reciprocity and norms of cooperation, a sense of obligation to help others, and confidence in return of assistance
- Trust in the community
2.8 Cross-National Comparison

This thesis includes an international, cross-national comparison with Alberta, Canada as the literature shows such an approach can offer a deep understanding of the socio-cultural practices of societies and provide unique insights into existing practices. Alberta, like Scotland, has experienced deinstitutionalisation spanning decades and like Scotland, the Canadian government has embarked on a policy of recovery for its mental health services. Both locations are characterised by remote, isolated communities separated by vast distances but the landmass of Alberta is considerably larger than Highland, suggesting that rural living may have different implications for participants in Canada. Moreover, the empirical sites in Alberta are relatively new in comparison to Highland, again offering the potential for key differences between the two countries in terms of entrenched community attitudes to difference. Canada is also useful as a comparative site given the similarities in culture and language, and the strong historical connections between Scotland and Canada linked with the mass emigration of Scots in the 18th and 19th centuries (Scotland 2004). Indeed, data from the 2006 census in Canada showed that there were 661,265 reported Canadians of Scottish descent (20% of the total population for the province) living in Alberta\(^8\) (Statistics Canada 2006). However, Canada also has different populations compared to Highland. Specifically, the Aboriginal Peoples, comprising First Nations, Inuit and Métis, highlight the cultural diversity of the country and potentially offer different findings in terms of research on mental health given their poor health outcomes and their vulnerable status (Alberta Health Services 2011a).

This section briefly outlines how (rural) mental health issues have been framed in the wider Canadian literature. The following section will provide an overview of current relevant debates within the Canadian literature, including more specific literature related to rural mental health.

In Canada, each province has its own mental health care system but common features include a mix of institutionally based mental health services delivered by unionised professionals (e.g. in Community Mental Health Centres) and by less regulated voluntary sector providers, and also universal health care for all at the point of entry (the publicly funded Medicare system) for hospital and GP services (including hospital-based

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\(^8\) Across Canada, the census showed that 4.7 million Canadians stated they were of Scottish descent. At the time the entire Scottish population was just under 5.2 million.
psychiatrists), but, there is no public coverage for specialist services such as psychology (Drake & Latimer 2012).

Historically, mental health has not featured highly in health policy discourse in Canada and until recently, it was the only G8 country without a national mental health strategy. Recently, the landscape has changed with the publication of the national report on mental health ‘Out of the Shadows at Last’ (Standing Senate Committee on Social Affairs, Science and Technology 2006) and consequent emergence of the Mental Health Commission of Canada (MHCC). Key initiatives include the anti-stigma programme Opening Minds, the introduction of a Knowledge Exchange Centre, and the introduction of a mental health strategy for federal government (see Toward Recovery and Well-Being); highlighting a clear mental health system reform and alignment to recovery-orientated policy and practice. Nevertheless, according to Health Canada (2009) mental health problems are a persistent concern for the federal government, with one in 10 affected by anxiety disorders (Canada ranks 27th of 29 OECD countries in public spending on disability related issues, and is below average in its support of social integration of persons with disabilities (Mikkonen & Raphael 2010)). Although there have been continual efforts to tackle the stigma associated with mental illness, evidence suggests that it is an on-going problem both from public attitudes (Canadian Senate Committee on Social Affairs, Science and Technology 2006; Ontario Human Rights Commission 2009) and from mental health professionals (Mental Health Commission of Canada 2012).

Despite a policy of deinstitutionalisation stemming from the 1960s, community-based mental health services in Canada have not been developed appropriately due to scarce resources and fiscal restraints (Health Canada 2002). From the mental health services literature it can be seen that concerns centre on providing services to dispersed populations, given the sheer scale of rural areas (Wang 2006; Haggerty et al., 2010; Dyck & Hardy 2013) and problems with waiting times (Vallerand & McLennan 2013). In overcoming some of these challenges, studies have looked at more integrated collaborative working in mental health care (Farrar et al., 2001).

Other concerns focus on cultural variations; poor communication between health professionals (Gagné 2005) and the levels of mental health problems in Canadian children after infancy; 14% of children aged 4 to 17 years currently experience mental disorders (Waddell et al., 2005). There is also a focus on how to encourage the uptake of mental health services given the low levels of utilization by those who need them.
(Tempier et al., 2010; Rhodes et al., 2006); GPs are the most widely accessed resource for mental health problems and self-help groups the least (Fournier et al., 1997; Statistics Canada 2003). Research by Lesage and colleagues (2006) found that only 40% of Canadians with a self-reported mental disorder used health services for their mental health (however, for those who do, help is sought from more than one source, suggesting a potential for more focused collaborative working between services).

A survey by the Canadian Medical Association (2008) found that 21% of participants did not seek any help despite experiencing some issues associated with mental illness; 42% of participants would no longer socialize with a friend diagnosed with a mental illness, whilst 46% believed that a diagnosis of mental illness was merely an excuse for ‘poor behaviour and personal failings’. A number of participants (61%) reported that they would not use a family doctor with a mental illness. Research by Jagdeo and colleagues (2009) also found that negative attitudes towards mental health service use are still prevalent in Canada: 20% of respondents would not seek treatment if they had serious emotional problems and almost 50% of respondents stated they would be embarrassed if their friends knew about their utilization of mental health services.

Public attitudes towards mental illness in Canada are not straightforward. In a survey exploring attitudes of the public towards schizophrenia, Thompson et al. (2002) found that respondents demonstrated a reasonable acceptance of schizophrenia, with the majority willing to pay higher taxes to support progressive programmes for the mentally ill. However, acceptance was less so for situations where personal contact was likely, and fears of dangerousness associated with the condition remained high. In line with this, despite finding negative attitudes towards mental illness, the Canadian Medical Association (2008) also found that 60% of respondents believed the diagnosis and treatment of mental illness was underfunded, despite expecting numbers of people diagnosed to increase over the next 10 years.

O’Hagan et al. (2010) identify five key risk groups in Canada for mental health problems: youth (adolescent and young adults), trauma (abuse and neglect in early life, war, physical or sexual assault), inequality (relative poverty, lack of hierarchical status and racism), fragmented communities as a result of extreme individualism and the loss of shared values and deculturation. The Aboriginal peoples of Canada (First Nations, Dene, Metis, and Inuit) appear to be a prominent risk group in terms of mental health issues. Rates of depression, suicide and addictions are significantly higher compared to the rest of the Canadian population (Marr, et al., 2009; Mikkonen & Raphael 2010; Alberta
Health Services 2011a). First Nations youth commit suicide up to six times more often than non-Aboriginal youth and suicide has been found to be the leading cause of death for First Nations adults up to 44 years of age (Health Canada 2003). The problem of access for Aboriginal people is a considerable challenge (O’Hagan et al., 2010; Dyck & Hardy 2013).

In contrast to the UK, the concept of social inclusion does not feature prominently in the mental health literature in Canada. Concepts such as community participation in health promotion (Boyce 2002) and social determinants of health (Marr, et al., 2009; Mikkonen & Raphael 2010) are particularly prominent in relation to shaping health policy (the latter model emerging from 1974 with the publication of the Lalonde Report, Jacklin, 2009). However, despite differences in terminology, there is recognition within the literature of the potential for social isolation as a result of mental illness, and its consequent implications for quality of life (Health Canada 2002; Whalen 2009; Canadian Institute for Health Information 2011).

Overall, research on mental health in Canada is less prominent than the UK. A significant number of Canadian studies on mental health are quantitative (Vasiliadis, et al., 2005; Lunsky et al., 2007, Bahm & Forchuk 2008; Sewitch et al., 2008; Satyanarayana, et al., 2009; Tempier et al., 2009) despite the suitability of qualitative work to inform mental health reforms (Davidson, et al., 2008).

2.8.1 Rurality

Approximately 20% (6 million) of the Canadian population reside in rural and northern communities (Statistics Canada 2009a). Findings from a Public Health Agency of Canada Think Tank (2005) found that respondents identified a number of benefits to rural living in Canada: a sense of community, a sense of security and the rural ‘way of life’ were common themes. Nevertheless, rural communities in Canada often face significant challenges with fewer resources (Richgels & Sande 2009). Social and medical services are often located in densely populated areas, with those living in more remote areas having to travel considerable distances to access them (Lunsky et al., 2007).

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9 Determinants of health: the range of personal, social, economic and environmental factors that determine the health status of individuals or populations (WHO, Health Promotion Glossary, 1998). The determinants of health can be grouped into seven broad categories: socio-economic environment; physical environments; early childhood development; personal health practices; individual capacity and coping skills; biology and genetic endowment; and health services (Alberta Health Services 2011b)
A literature review on health and rurality by Minore and colleagues (2008) identified several key areas for consideration in rural health service design in Canada: equity of access, rural needs, costs of rural services and funding. The authors found that health service provision in rural areas of Canada is more costly due to reasons such as recruitment and retention of rural health professionals, the unproductive time spent travelling to dispersed populations for outreach (involving lower caseloads) and the additional costs of developing sustainable health services. However, the researchers also highlight that official statistics may not accurately reflect the level of need for rural dwellers, ‘Dichotomous definitions that compare rural to urban populations may mask differences within rural populations and lead to inequitable access and or an inaccurate assessment of the needs of rural populations’ (ibid. p. 106).

Similar to the UK, there is a lack of consideration of the needs and experiences of rural mental health service users in Canada (Boydell et al., 2006). In their exposition of social exclusion and its impact on health, Mikkonen and Raphael (2010) present evidence demonstrating its effects, both physical and social, for a number of marginalized communities (such as new immigrants) to Canada but they focus exclusively on urban areas.

From the literature it can be seen that rural dwellers face considerable barriers in accessing appropriate mental help support (Henderson et al., 1991; Standing Senate Committee on Social Affairs, Science and Technology 2006), included within this are problems with transport (e.g. lack of transport and transport costs involved in travelling to urban areas for mental health support) (Boydell et al., 2004). Despite the need for availability and choice in relation to rural mental health services, these areas are often the last to receive services (Bodor 2009). According to the Mental Health Commission of Canada (2009b) only one third of Canadians currently requiring mental health services actually receive them, adding that 'the situation is worse for some populations and for remote and rural communities in the north and elsewhere' (p. 17). However, this is further complicated by the fact that even when services are available locally, long wait times; lack of information; stigma, and lack of anonymity can deter residents from accessing services (Dyck & Hardy 2013).

Unlike Scotland, Canada has different populations. As previously noted, Aboriginal people in Canada represent a particularly vulnerable population (Alberta Health Services 2011a). They have a greater incidence of ill health compared to the non-indigenous population (Statistics Canada 2007) most notably with cases of tuberculosis (Boffa et al.,...
Significant challenges are also documented in terms of living on reserves, particularly in relation to crowded housing and unsafe water (Reading & Wien 2009; Statistics Canada 2009). In a study examining First Nations women (on reserves) and depression in Ontario, MacMillan et al. (2008) found that rates of depression were twice as high compared to women from the non-Aboriginal population. The research found that a significantly higher proportion of women living in remote/special access communities reported that they felt like taking their own lives, compared to those in urban communities, and that distress interfered with their activities. In terms of the current study, this difference in populations makes a cross-national comparison even more interesting and potentially offers a unique contribution to the knowledge base.

Consideration needs to be given to rural cultural norms and values. Qualitative work by Leipert and Reutter (2005) found that norms and values associated with hardiness and self-reliance inhibited women from seeking help in northern and rural communities and further perpetuated the stigma associated with mental illness. As a result, the women were found to cope by internalising these norms and developing resilience through the strategies of ‘becoming hardy’. In tracing these attitudes, Cates et al. (2012) note the way in which reliance on self and kinship ties helped rural and frontier people to survive in remote, isolated and difficult environments:

‘That residents of rural and frontier areas tend to initially rely on the two informal levels of social support may in part be due to their self-reliant tendencies aggravated by geographic location and/or isolation, inability to access or qualify for services, inability to pay for services and lack of service providers. This also may be due to cultural traditions regarding the accepted traditional method of handling mental health issues (or if the concern is even acknowledged as a significant issue), a shared belief that outsiders are not to be trusted, resentment of outsiders coming to “rescue” them, and/or negative perceptions of the value of formal services in addressing the issue’ (p. 23).

Indeed, the notion of pride and independence were found to be the single most cited reason why Canadian farmers did not seek help in dealing with stress and mental health (Canadian Agricultural Safety Association 2005).
The Canadian voluntary sector plays a key role in its rural service provision. Such organisations are considered ‘the very fabric of the community’ (Bruce et al., 1999). Recent cutbacks of social programmes by the public sector has resulted in an even greater reliance on the voluntary sector as a ‘beacon of hope’ for those in need of assistance (Chouinard & Crooks 2008). The federal government has moved towards a new model of public administration, with the emphasis on ‘horizontal governance’ or collaborative working with non-profit organisations (Phillips & Levasseur 2008) in order to enhance the relationship and strengthen the sector (Voluntary Sector Initiative 2011), themes also evident in the UK (see section 2.6.2). Nevertheless, the rise in demand for non-profit services has been at odds with funding available from government in addition to increased competition with the private sector (Cloutier-Fisher & Skinner 2006). Along with restricted funding, the government has also put in place accountability measures that have put additional pressure on voluntary organisations (Hanlon et al., 2007). According to Eakin (2001) the current funding climate has weakened the capacity of voluntary organisations, which now has implications for future sustainability. Indeed, diversification in terms of funding sources has meant increased financial volatility, resulting in less security and independence for such organisations (Scott 2004). As previously highlighted, rural areas are often under-serviced and struggle to meet basic service needs. This has put even further pressure on existing voluntary organisations (Skinner 2008). The increasing reliance on voluntary organisations in Canada, coupled with restricted funding, suggests that the challenges for the sector in both countries may be similar.

2.8.2 Summarising Cross-National Comparison

The literature from Canada paints a negative picture in relation to mental health service provision. Specifically, fewer mental health care resources due to populations spread over a large geographic area, the considerable costs involved in travelling to access help and a limited number of mental health professionals all combine to create unique challenges for rural dwellers who experience mental health problems and consequently need help (Henderson et al., 1991). Moreover, rural cultural attitudes around help-seeking combined with generally negative attitudes to mental health compound this situation further. The voluntary sector is often relied upon in local communities to fill the gap left by formal services, however, in the current climate such organisations are facing increasing pressure due to changes in the relationship with the federal government (Cloutier-Fisher & Skinner 2006).
In a similar way to the UK, there is a dearth of studies that have looked at the experiences of rural mental health service users in Canada. Research that explores these factors can therefore offer an important contribution to the knowledge base.

**2.9 Conclusions: Key Debates and Gaps in Knowledge**

This chapter has used the literature to demonstrate an understanding of the background to mental health research. It has framed the subject within the wider literature, exploring current debates and their relevance for the study. It has been shown that the literature provides compelling evidence to suggest those who experience mental health problems are at increased risk of social isolation, often compounded by stigma and discrimination (Sayce 2000). They also lack access to employment opportunities and have less access to social networks compared with the rest of the population. Nevertheless, the concept of social inclusion remains contested and is criticised for its shifting discourses (Levitas 2006); it remains unclear who exactly is included and into what. There is also concern around the centrality of paid work as part of its deployment, linked with an on-going agenda that is concerned with promoting personal responsibility. The concept does, however, offer an important way of addressing inequalities that are disproportionately experienced by mental health service users. In particular, its use as a policy directive is important because it focuses on the structural forces that can promote inclusion and thereby provide greater opportunities for participation to those who are often constrained.

The concept of recovery has become increasingly prominent in mental health policy in recent decades. Many western countries have embraced the concept at a political level but Scotland and Canada have been particularly ardent. However, as with social inclusion, recovery lacks a clear consensual definition. Common themes include hope, healing, gaining control and the right to a meaningful life. Further research is needed to expand the current knowledge base around recovery as its promotion of self-determination and of listening to service users as experts in their own mental health suggests it has much to offer.

The literature also highlights the key role good social relations (social capital) can play for a person who experiences mental health problems. For example, having access to friendship and social support can act as a buffer against stress and can influence wellbeing and self-esteem (Mckenzie & Harpham 2006). Conversely, a lack of adequate social networks can increase the chances of relapse and reduce overall recovery (Royal
Social capital also has the potential to create opportunities for participation thereby linking to the overarching theme of social inclusion. Whilst there are issues with definition, terms such as ‘trust’, ‘social networks’ and ‘connections among individuals’ are core themes. However, the literature demonstrates that social capital in the field of mental health is still at the earliest stages of theoretical understanding. At a policy level, social capital has been promoted as a resource that can potentially reduce social exclusion and stigma for service users, nevertheless it is unclear exactly how this works or the key mechanisms involved that can be used to achieve this. Further studies are therefore needed to enhance the knowledge base. Critical examination of the concept is necessary in order to understand its role in promoting better outcomes for mental health service users (potentially decreasing the problems of stigma and social exclusion). Furthermore, policy discourse around localism highlights an increasing emphasis on building the capacity of local communities: context-specific research that incorporates social capital as part of its analysis is therefore relevant and timely.

A key focus of this thesis is the role of the voluntary sector in rural areas. The literature demonstrates the ways in which rural voluntary organisations play a key role in delivering health and social care support. They also provide support when other (formal) services are lacking. However, increasing competition combined with a growing reliance on the sector have created challenging conditions for voluntary organisations and have left some rural communities vulnerable and at risk. Despite the policy of deinstitutionalisation and an increasing reliance on the voluntary sector in rural areas, the knowledge base is limited with regards to understanding the contribution of such organisations, in particular if, and how, they help rural service users as part of ‘care in the community’. Such factors highlight the need for a renewed understanding of the contribution of rural voluntary organisations, within the context of mental health.

There is also limited research on the perceptions of rural health professionals, however, recruitment and retention is a clear theme. Arguably, the overlap between the public and private domain is a contributory factor in why some professionals choose not to practice in rural areas. A further dimension here is that rural cultural attitudes around help-seeking and a generally negative outlook on mental health problems suggests this can present a number of challenges for rural mental health professionals in terms of engaging those who require help. It is, therefore, important to understand more about these
challenges for service providers in order to develop a comprehensive picture of rural mental health service provision.

Accessibility and availability of specialist rural mental health services can have significant implications in terms of help-seeking pathways for those with mental health problems. Additionally, whilst rural communities are often characterised as close-knit, such closeness, combined with high visibility, can act as a deterrent for individuals presenting to primary services for help (Nicholson 2008). In this way, acceptability is also a key factor. Providing mental health services in rural locations may be challenging because of such factors (Deaville 2003). Nevertheless, a clear theme from the literature is that rural areas remain under researched. In particular, there is little in the way of research that explores the potential benefits of being part of a rural voluntary, self-help group for those who experience mental health problems (despite increasing emphasis on localised solutions). This seems an important omission given that if services are to continue to adopt inclusion as a guiding principle, based on government strategy, it seems logical that the knowledge and experience of those who have faced mental health problems is what drives this development. As Repper and Perkins (2003) suggest ‘Unless the concerns of service-users can be tapped, it is not going to be possible to develop services that enable them to rebuild valued and satisfying lives’ (p. 183). Unless this is addressed, the policy of inclusion simply becomes rhetoric for all those involved in planning and developing mental health services. In particular, there is a need to explore how well public and voluntary services in rural areas meet the challenge of social exclusion for service users. Such research is crucial to ensure that policies and services are aligned to the needs of those they are intended for. It also ensures the knowledge base accurately reflects the lived experience of those with mental health problems, within a rural context.

2.10 Final Overview

According to Parr et al. (2004) there is limited mental health research in remote and rural areas. They suggest that further research is, therefore, needed to interrogate the role of psychiatric service delivery and service user networks in combating isolation, thereby contributing to critical thinking on social exclusion and how it can be mitigated in a rural context. This thesis responds to this and seeks to assess whether community-based mental health services are aligned to the needs of those they are intended for, and, whether they facilitate social inclusion for those living in remote and rural areas. The thesis explores the potential of voluntary organisations to provide mental health services
in rural areas in a way that helps to overcome many of the social exclusion challenges highlighted in previous research. As noted by Sayce (2001) research on the impact of initiatives or services to enhance social inclusion is crucial to ensure they are grounded in an evidence base. The thesis will compare current mental health models in the Scottish Highlands with that of Alberta, Canada. It is hypothesized that physical isolation as a result of geography, and historically greater levels of stigma associated with mental illness, are likely to exacerbate the problem of social exclusion and restrict access to services.

The five key research questions of the present thesis correspond to the gaps identified in the literature review:

1. **What does it mean to experience mental health problems in remote and rural areas?**

2. **What are the challenges that service providers face in remote and rural areas?**

3. **What benefits are there for service users attending voluntary groups in remote and rural areas?**

4. **Do voluntary groups offer something that other rural mental health services do not?**

5. **Is social capital useful for understanding the benefits and role of mental health voluntary organisations in a rural setting?**
CHAPTER 3

METHODOLOGY AND RESEARCH METHODS
3.1 Introduction: Mixed Qualitative Methods for Understanding the Experience of Remote and Rural Mental Health Services

This is a qualitative study using focus group and individual interview methodology. The current chapter outlines the justification for this methodology and the specific approaches used. The chapter starts with a discussion of the use of qualitative methods in health research and the rationale for using qualitative methods in the research design. The chapter then lays out the study design before presenting an overview of the two locations (Highland and Alberta) including details of the empirical sites. The recruitment procedure for participants is also presented. The chapter then presents the methods before discussing the specific research techniques employed to produce the results detailed in the following four chapters. Overall, this chapter demonstrates the ways in which the methods chosen for this research are deemed to be the appropriate tools to answer the research questions detailed in Chapter Two.

3.2 Qualitative Methods in Health Research

There is increasing emphasis on capturing the views of those who use health care services to shape future delivery of these services (Dewar *et al.*, 2010). Exploring the views of those who use health care services has been approached in a number of ways, including surveys, interviews and focus groups (Scottish Government 2006b; Lucock 2007; Jones *et al.*, 2009). However, in health research, empirical findings have largely been produced within a quantitative paradigm, mainly due to the fact that the results are amenable to statistical analysis and generalizable to a wider population (Powell *et al.*, 1996).

Nevertheless, the past decade has seen the emergence of an increasing number of qualitative contributions in healthcare research (O’Cathain *et al.*, 2007; Turner *et al.*, 2013) particularly in rural health research (Harvey 2010). This greater use of qualitative methodology has occurred for a number of reasons. Firstly, increased methodological rigor within the qualitative paradigm has made this approach more acceptable to those trained within a predominantly quantitative paradigm. More recently, health service researchers have combined both strategies (i.e. mixed methods) in an effort to generate deeper insights (O’Cathain *et al.*, 2007).

Qualitative assessments provide a holistic view of the phenomena under investigation and, additionally, allow for context to be included in the analysis (Brannen 2005). Moreover, they offer flexibility in the interpretation of collected information (LeCompte...
2000); given the complexity of mental health, it would seem such factors are of particular importance when considering a research design. As noted by Powell and colleagues (1996) whilst quantitative findings are generalizable to a wider population, the issue of validity becomes pertinent if the questionnaires used only partially address the topic under investigation. In the context of mental health, such methodological issues become even more pronounced; an individual’s experience can be impacted by a combination of factors that are physical, psychological and social in nature. In addition, the subjective nature of mental health problems is often mediated by cultural context (Groleau et al., 2007); given the international comparative element to the study, this seems a particularly important issue. Qualitative assessments therefore offer greater validity to the study and provide the opportunity to gather rich experiential data in the words of participants themselves.

The importance of using qualitative methods in mental health research is also highlighted by Jones et al. (2009). Their work aimed to explore the views of service users and carers in relation to continuity of care. Through qualitative interviews, the study explored users’ and carers’ relationship with services and in doing so, led to a number of key findings. In particular, the study found that a high turnover of staff within services can have major implications for service users on their road to recovery; continuity and well managed transitions (for service users) were found to be key areas for service providers to focus on in providing good quality services. Additionally, it was found that both service users and carers advocated a more preventative strategy by services, rather than response to crisis. Other similar work has also been carried out (Briner & Manser 2013; Gault et al., 2013).

As noted earlier, Parr et al. (2004) have also contributed much within this area through their qualitative work. Using semi-structured interviews and focus group discussions they were able to gather rich data on the views of both service users and providers in the Highlands. Their qualitative assessments enabled participants to share their experience around mental health problems in a rural context. Moreover, their findings have highlighted some of the challenges that rural services face within the context of social inclusion. In particular, the issues of high visibility, stigma and transport were noted to be perennial themes.
3.3 Research Design

The research for this thesis has been carried out in line with qualitative approaches by employing two research methods. The choice of methods stems from the research design, which in turn was linked to the initial identification of the broad area of research (see Figure 4). According to Bryman (2004) the research design relates to the framework for the generation of evidence that is suited both to a certain set of criteria and to the research question(s) in which the researcher is interested. Thus, the decision to explore rural mental health in the context of social inclusion was due to the research lacuna in this area. This led to the formulation of research questions that were focused on exploring the rural experience for service users, understanding the contributions of rural mental health voluntary groups and understanding what the challenges are for service providers. The most appropriate way to capture this was through in-depth qualitative research methods involving focus groups and semi-structured interviews. Understanding the lived experience of mental health was in turn captured within a social inclusion and service utilisation framework.

The importance of interpreting how participants understand and make sense of their social world (through qualitative methods) taps into a key theme in the social sciences on methods of reasoning: *inductive* and *deductive*. The former is open-ended and exploratory in nature, where the process of induction involves drawing generalizable inferences out of observations. In this way theory is the outcome of research. Conversely, the ‘hypothesis first’ approach of deductive reasoning derives from the physical sciences in which there is no question of human intentionality and the need to interpret, for example, the 'behaviour' of molecules. In deductive reasoning, the researcher, on the basis of what is known about in a particular domain and of theoretical considerations in relation to that domain, deduces a hypothesis (or hypotheses) that must then be subjected to empirical scrutiny (Bryman 2004). Deductive reasoning moves from a general theory down to particular examples, while inductive reasoning moves from particular examples up to general theory. Nevertheless, it is questionable how distinct these approaches are in the social sciences given that both forms of reasoning entail an element of each other; the researcher cannot proceed on the basis of purely inductive reasoning from observation without importing their own conceptual influences (i.e. their interpretations and tacit hypotheses about what people are saying and doing), similarly drawing from theory and testing an hypothesis still involves induction as the researcher
infers the implications of his or her findings for the theory that prompted the whole exercise (Bryman 2004).

The current study adopts the position that social scientific understanding is a matter of mutual assimilation between the meanings assigned, respectively, by the observer and the observed. Within the mental health system primacy has often been given to expert knowledge. Such knowledge has generally been informed by quantitative methodologies that seek to generalize and explain objective phenomena through reductionism, knowledge which has been referred to as nomothetic. In contrast, ideographic knowledge seeks to understand meaning and subjective knowledge, or the life-worlds of individuals, informed through qualitative methodologies (see Slade 2012). The current study therefore aligns itself with the idea that human behaviour is subjectively meaningful; description, explanation and prediction have to take full account of that and enter, as it were, a ‘dialogue’ with the subjects of the study. Interpretation is then based on a number of levels: the interpretation that participants make about their experience of rural life as a service user; the researcher’s interpretation of that; the interpretation in relation to the research questions and finally the fourth level, namely the influence of the wider literature and how such meanings find their place in relation to that wider body of knowledge.
Figure 4: Thesis Research Design

Broad Research Area:
Mental Health Services and Social Inclusion in Remote and Rural Areas

Areas of Knowledge Required

Lived Realities

The Meaning of Places and Experience

In-depth Qualitative Methods

Social Inclusion

Service Utilisation

Interpretative Frameworks

Cross-National Comparison
(Highland and Alberta)
3.4 Context for carrying out mental health research in Highland and Alberta

3.4.1 International Comparison

The current study involves an international comparison between the Highlands of Scotland and Alberta, Canada. A comparative research design is useful in that it allows for a better understanding of social phenomena when it is compared in relation to two or more meaningfully contrasting cases or situations (Bryman 2004). In the context of mental health, it has the potential to identify common and regionally/culturally specific aspects of the experiences of service users and providers. The current study will adopt a working definition of an international comparison as provided by Hantrais (1995) who suggests:

‘….a study is held to be cross-national and comparative, when individuals or teams set out to examine particular issues or phenomena in two or more countries with the express intention of comparing their manifestations in different socio-cultural settings (institutions, customs, traditions, value systems, lifestyles, language, thought patterns), using the same research instruments either to carry out secondary analysis of national data or to conduct new empirical work. The aim may be to seek explanations for similarities and differences, to generalise from them or to gain a greater awareness and a deeper understanding of social reality in different national contexts’

3.5 Research Fieldwork

3.5.1 General Area Profiles: Highland

In order to assess current service provision in remote and rural areas, it was felt the Highlands of Scotland and the province of Alberta in Canada would be the most suitable empirical sites. Both locations are characterised by remote, isolated communities separated by vast distances. The Highlands of Scotland is a sparsely populated region (n-
222,370), covering more than half of the land mass of Scotland as a whole (39,050 km$^2$) but with only 4% of the population. The area stretches from Shetland in the north to the southern tip of Argyll and includes almost 100 inhabited islands. The terrain is rugged and barren in large parts, covering the northern two thirds of Scotland. Settlements consist of remote crofting communities, villages, towns (located on the mainland and on the surrounding islands), and one city (Inverness) with most population settlements located along the coastal plains. The economic base of the area is characterised by primary industries such as agriculture, forestry, fishing and, more recently, renewable energy.

In terms of mental health service provision, this is provided by NHS Highland and the coterminous Highland Council, in partnership with a broad range of voluntary sector services and not-for-profit care providers (see Figure 5). The non-government sector organisations (e.g. VOX ‘Voices of Experience; SDC ‘Scottish Development Centre for Mental Health’; HUG ‘Highland User Group’ and SAMH ‘Scottish Association of Mental Health) represent the most open organisations in the mental health services landscape. They act as contractors who are commissioned by local authorities in order to provide a broad range of services. They also act as vehicles for promoting the voices of service users and in influencing policy development.
Figure 5: Organisations by openness and proximity to central government (Source: Smith et al. 2008)
In terms of specialist help, this remains located in what is now known as New Craigs Hospital (formerly Craig Dunain). The hospital covers the Highland area and has 72 acute beds, with a 12-bedded Intensive Psychiatric Care Unit. Services offered at the site include day care clinics and acute inpatient residential facilities, with both short-term and long-term admissions, and also psychiatric services for older adults (Scottish Government 2003). Nevertheless, in terms of crisis services, New Craigs covers the whole of the Highlands making it difficult for a service user located on, for example, the island of Skye to access it (travel time would be approximately 2 hours). Indeed, the challenge of accessing the hospital for rural service users in crisis is compounded by the difficulty in getting appropriate escorts and limited out-of-hours service capacity (Highland Users Group 2003).

More generally, in terms of the geographical distribution of community-based mental health services, these are often centralised in more populated areas of the Highlands making access difficult for service users from surrounding rural areas (Voices of Women in Rural Scotland 2012).

### 3.5.2 General Area Profiles: Alberta

Alberta is Canada’s fourth largest province in terms of population (n=3,290,350) however, in a similar way to Highland, the rural population totals 590,499 (Statistics Canada 2011). Nevertheless, the landmass of Alberta is considerably larger at 642,317 km² (Statistics Canada 2005). The province is landlocked, bordered by the Northwest Territories to the north, Saskatchewan to the east, the US state of Montana to the south and British Columbia across the western border of the Rocky Mountains. The landscape of Alberta is diverse including mountains, heavy forested areas and peat lands in the north, to the flat extensive grasslands in the south (Alberta Canada 2013). While its economy is diverse (e.g. manufacturing, forestry and energy renewables), its primary industry is agriculture.

In recent years, Alberta health care delivery has undergone significant redesign, with the amalgamation of its nine regional health authorities, its Mental Health Board, the Alberta Alcohol and Drug Abuse Commission and the Alberta Cancer Board into a single health authority (known as Alberta Health Services) (Alberta Health Services 2011b). In terms

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10 There is also a Travelling Day Hospital which provides services outside the Inverness area.
of mental health service provision, acute adult inpatient facilities are located in the major urban centres of Calgary and Edmonton, and also in various places around the province. For example, Medicine Hat (south east of Calgary) is an acute facility with 31 beds, the inpatient psychiatric unit at Northern Lights Regional Health Centre has 10 beds (north east of Edmonton), Red Deer Regional Hospital (located between the 2 major urban centres of Calgary and Edmonton) has 32 inpatient beds and The Centennial Centre for Mental Health and Brain Injury has 157 inpatient beds (also located between Calgary and Edmonton). There is also a considerable number of community-based mental health services concentrated in or near Calgary\textsuperscript{11}. For the rest of the province, there are a number of Community Mental Health Centres consisting of a range of allied mental health professionals (similar to the UKs Community Mental Health Teams) who provide assessment, intervention and community support. Nevertheless, the sheer scale of the land mass has had significant implications for equitable service delivery in Canada: many rural dwellers still do not have access even to basic mental health services let alone specialised ones (Dyck & Hardy 2013). To compound this, poverty, poor transportation and geographic factors mean psychiatric resources remain inaccessible for many rural dwellers who require mental health support (Henderson et al., 1991).

Like Scotland, rural Alberta faces challenges around stigma (Canadian Medical Association 2008) which can potentially create a barrier in terms of treatment and community acceptance. According to Alberta Health Services (2013) over 500,000 Albertans (approximately 16\% of the population) receive at least one mental health service from a GP each year (primarily linked with anxiety disorders). Nevertheless, this may underestimate the true scale of the problem as it does not account for those individuals who choose not to seek treatment given that Canadian rural culture is characterised by conservatism, negative attitudes to mental health, a valued notion of self-sufficiency and the use of informal networks of control (Henderson et al., 1991). Given the predominantly rural nature of its landscape, it is arguable that rural culture could potentially be a contributory factor in the uptake of services for those living in more remote and rural areas of Alberta.

\textsuperscript{11} There are currently 1500 different addiction and mental health services for people of all ages within the community of Calgary and Alberta Health Services
http://www.albertahealthservices.ca/services.asp?pid=service&rid=2381
3.5.3 Political and Socio-Cultural Landscape

The current thesis is situated within a social policy context. As such, it is important to acknowledge the political and socio-cultural dimensions of both countries. Both locations have a number of agents involved in mental health service provision (primary services, statutory services, private and voluntary sector organisations). In the past two decades, like the UK, Canada has seen an increasingly dominant role of the private sector (Teghtsoonian 2009) which has had implications for voluntary sector organisations, such as increased competition for funding (Evans et al., 2005). Both countries have also undergone a process of deinstitutionalisation for over forty years. Despite these changes, both governments now acknowledge mental health as a significant public health issue and have devoted increasing attention to how best to manage the prevention and treatment of mental health problems (Scottish Government 2009a; Public Health Agency of Canada 2006).

Both countries also have significant periods in history that continue to exert an influence in the contemporary landscape. In Highland, historically the region has been characterised by a deep sense of loss and displacement linked with the ‘Clearances’, when large numbers of Highland dwellers were forcibly removed from their land by landowners who turned to more profitable forms of farming (i.e. sheep farming instead of arable farming). This 70 year period in the Highlands (from the middle of the 18th century), arguably devastated the Gaelic culture and clan system, forcing many to emigrate to countries such as Canada and America in search of a better life. The eighteenth century was a particularly important period in the history of the Highlands of Scotland. It signalled a radical redefinition of land ownership and put an end to the traditional clansman’s relationship and right to ancestral land:

‘When the new landlords decided that their estates could be made more profitable only by clearing them of their occupants, that principle [of ancestral rights] was abandoned; Highlanders were relocated without regard to the ability of their new sites to sustain them. The tragedy of the Clearances was the arbitrary eviction of a people, and the pauperism, malnutrition, ill-health and disease which followed that eviction’ (Mathieson 2000, p. 5).
In the modern context, this chapter in history has arguably cast a long shadow. In little more than half a century, the region became one of the most sparsely populated areas in Europe, and remains this way to date. Moreover, whilst many of the Highland people vanished, the homes and collective settlements were also cleared, with only remnants suggestive of what social life would have looked like then; essentially forcing a disruption and a disconnection to historical roots for many locals in the modern age: ‘Most countries in Europe can display examples of traditional peasant housing going back to the Middle Ages. This is true of England and, to some extent, southern Scotland. But when one comes to the Highlands there are very few buildings of this sort that date from before the early 19th century…The only way a 21st-century Highlander can experience something of how his or her ancestors lived 300 years ago, is to visit the archaeological reconstruction of a Highland township (or baile) at the Highland Folk Museum in Newtonmore’ (Noble 2011).

**First Nation Canadians**

A specific issue in Canada, for which there is not a comparator in the Highlands, centres on its indigenous First Nations people (see First Nations Health Council 2013). In terms of mental health, the First Nations suicide rate is more than twice the Canadian rate, with youth suicide rates estimated to be five to seven times higher than that of non-Aboriginal youth (Chenier 1995; Health Canada 2006). Whilst suicide is complex and can be compounded by a number of factors, within the Canadian context, Aboriginal suicide is linked with loss of culture and a history of traumatic events (Isaak *et al.*, 2010). More specifically, the historical Indian Residential Schools system, set up in the late 19th century, relates to a period in Canadian colonial history reminiscent of Australia’s deculturalization program for its indigenous population. Following the Indian Act (1876) Canadian Aboriginal children were removed from their families and forced to attend government-funded residential schools that were run by Christian churches. The aim of the system was to assimilate the indigenous population into the dominant white culture (by adopting the English language and by converting to Christianity) thereby expelling the native ways for subsequent generations. However, as is now widely acknowledged and accepted, the catalogue of physical, emotional and sexual abuse that was carried out within those schools has left a devastating legacy for First Nations people. As the Aboriginal Healing Foundation (AHF) suggests:
‘Thousands of Aboriginal people who attended these schools have reported that physical, emotional, and sexual abuses were widespread in the school system. The equally powerful cause of trauma reported by former students, their families, and their descendants is the loss of culture and language, and the lifelong effects on people who, as children, were institutionalized in settings alien to them, away from their families and social networks. The legacy of this trauma has reverberated throughout Aboriginal communities until the present’ (p. 8).

Given the anger and grief surrounding such a legacy (Partridge 2010), the level of need in terms of healing cannot be underestimated, both at a community level and an individual level (AHF 2009).

Despite official apologies by the Canadian government (e.g. the ‘Statement of Reconciliation’ in 1998 and the formal apology offered in 2008) the contemporary outcome of the colonial process has had significant social and economic consequences for First Nations people. The forcible disruption of native life and the imposition of colonial culture and values meant that many Aboriginal children experienced the loss of their own culture, of language and of links to Elders with their associated spiritual teachings. In addition, they were denied the opportunity to develop parenting skills and to pass those skills on to future generations (AHF 2009, p. 25). Consequently, a combination of poverty, poor housing and substance misuse, along with a lack of parenting skills, has meant that there are inter-generational trauma effects, with approximately three times as many First Nations children in the welfare system as there were at the height of the residential school program (Blackstock 2005). For children and families living on reserves, there is less access to quality of life and preventative services, particularly from the voluntary sector (Nadjiwan & Blackstock 2003).

The work of psychoanalyst Erik Erikson (1995), among the Sioux Indian tribe of the USA, is particularly relevant here. Observing the impact of the federal Indian education system on the Sioux people and their children, Erikson noted the enormous disruption of cultural identity caused by the system, leading to extreme psychological consequences mainly due to their treatment by European settlers. Forcing government-run schools and their associated values on the Sioux children was, according to Erikson, akin to a ‘guerrilla war over the children’ whose impact was, and remains, far reaching.
‘differences in child training are of lasting and sometimes fatal significance in differentiating a people’s image of the world, their sense of decency, and their sense of identity’ (p.111). In terms of the current study, it is arguable that the Scottish Highland experience was a qualitatively different one. Specifically, the ‘Clearances’ and consequent loss of culture and way of life were a direct result of more profitable forms of farming. In this way the forcible disruption of the Highland dwellers way of life was linked with economic interests. The First Nations history, however, highlights a much more systematic attempt at dismantling the language, culture and essentially the very practices that defined who those people were as a nation.

3.5.4 Rural Comparisons

Any research that is conducted in remote and rural areas has to acknowledge the inherent difficulties that come with the term ‘rurality’; in particular, the lack of agreement as to its definition (Farmer et al., 1993). The definition of rural has become increasingly contested by researchers (Woods 2009) thereby leaving a limited evidence base for rural health issues (Deaville 2003). As noted by Brems et al., (2006) ‘a mere urban-rural dichotomy does not discern, for example, differences between a small rural community of 100 residents and a rural community of 2,000; nor does it differentiate a large urban area of two million from a smaller urban area of 50,000’ (p. 106). Such theoretical imprecision is particularly challenging when rural practice and policy issues are the focus for research (Bushy 2002). This is especially significant in terms of international comparisons. It is beyond the scope of this paper to solve such definitional issues. The research does not, however, remain insensitive to the different historical and geographical contexts within which different rural places are constituted (Philo et al., 2003), particularly when comparing rurality in Highland (i.e. sparsely populated) compared to rurality in Alberta (i.e. the sheer size of the province). As will be shown later (see Chapter 4), the study aims to unpack the reality of these rural environments and offer possible explanations for their differences.

In Scotland, the selection of sites was drawn from the Scottish Government’s Urban/Rural Classification System (2009/10). The classification is based upon two main criteria: population (as defined by the National Records of Scotland (NRS)) and accessibility (based on drive time analysis). There are two classification systems. The 6-fold system distinguishes between urban, rural and remote areas based on six categories, and an 8-fold system which further distinguishes between remote and very remote
regions (Scottish Government 2010a). According to this definition rural Scotland covers over 90% of Scotland’s land mass. The current study is based on the 8-Fold Classification System.

It is recognised that mental health service research may require the selection of representative geographical areas for data collection (Priebe, et al., 2008). In Canada, therefore, the aim was to select areas based on similar population sizes and relative remoteness. However, in one instance this was not possible. The organisation in the area that had been chosen had declined to take part in the research as the methodology was not Participatory Action Research. A similar occurrence happened in the next location that was chosen. The decision on which area to select after this was, therefore, partly pragmatic (i.e. the area had a voluntary drop-in and the organisation agreed to take part). It was under 60 minutes’ drive time to the next larger settlement (based on the 8-Fold Classification System, areas that have a drive time of under 60 minutes from a settlement with a population of 10,000 or more are classed as ‘Remote Area’).

3.5.5 Empirical Sites (Scotland)

As stated in Chapter One, two geographical areas were chosen as the research localities to be investigated in this thesis (Highland and Alberta). By exploring the experiences of rural dwellers residing in each of these localities, it was possible to consider to what extent these rural communities were similar in spite of differing political, social, economic and cultural dimensions. Much of existing mental health research draws from quantitative methodologies that are largely urban focused. The choice of these rural localities, therefore, allowed the research to investigate personal experiences and perceptions, essentially service user subjectivities, at a local level. This offered an important way in which to understand the impact of the rural environment on these experiences and also to consider how social inclusion is achieved.

In order to do this, the study incorporated three different sites in Highland. The first site was selected due to its location as an accessible island (Site A). The population is approximately 2,200 making its official classification ‘Very Remote Rural (with a population of less than 3,000)’. The second has an increased population compared with the other two sites at 57,960 and it is a large urban settlement serving a rural hinterland (Site B). The classification for this second site is ‘Other Urban Area (with a population of 10,000 to 125,000)’. Finally, the third site was chosen because, whilst still on the
mainland, it is geographically remote (Site C). The population is 7,340 and its official classification is ‘Very Remote Small Town (with a population of 3,000 to 10,000)’.

3.5.6 Empirical Sites (Alberta)

Across most official definitions, Alberta ranks amongst the highest in terms of its share of rural population, compared with other provinces (see du Plessis et al., 2002, p. 19). It therefore offered a good location for rural comparative research. The sites chosen in Alberta consisted of two in the north of the province and one in the south. The first northern site had a population of 17,286 (Site D) and was within 60 minutes’ drive time to a settlement population of over 10,000 (based on the 8-Fold Classification System, areas within a 60 minute drive time are classed as ‘Remote Area’). The second northern site had a population of 12,525 (Site D) and was also within a 60 minute drive time from a settlement with a population of 10,000 or more (‘Remote Area’). Whilst the third site in the south of the province had a population of 3,758 (Site F) and was just less than 60 minutes’ drive to a settlement of over 10,000 (‘Remote Area’).

3.5.7 Voluntary Organisations

The voluntary organisations that took part in the study were quite diverse in their origins, structure and objectives. The following section, therefore, provides an overview and some detail about each of these organisations in order to demonstrate their position in the local mental health landscape for each locality.

The first voluntary organisation (Site A, Highland) was started in 1992 by a group of interested mental health professionals and other community agencies (GPs, Psychiatric Nurses, Consultant Psychiatrist, Council on Alcohol, Community Advice Service, Council for Voluntary Organisations and other community members) who had identified a need in the area. The service is currently made up of a Board of Directors consisting of, among others, local GPs and members who use the service. The remit for the organisation is to provide a safe and secure place for people with mental health problems who might otherwise feel isolated. Besides referrals from formal mental health services, there is also an open access policy where people can self-refer. The organisation offers a range of services to members including crisis intervention, advocacy and practical assistance. In order to be more accessible for those living further away, the organisation also provides outreach work.
The organisation is primarily funded through NHS Highland but is also funded through various Trusts. Currently there are seven members of paid staff and two volunteers, who undergo various mental health training if and when the organisation can afford it. The organisation has strong links with the local Community Mental Health Team (the latter refer clients to the organisation for one to one support work) with meetings taking place each month between the two. The Consultant Psychiatrist that covers the area is also an advisor to their Board of Directors.

The second organisation (Site B, Highland) began in 1996. It emerged in answer to a perceived gap in terms of the access that rural service users had to local community mental health teams. The main aim of the organisation is to act as a voice for the mental health community and to campaign to improve the rights, services and treatment of people with mental health problems and indeed is run by those with lived experience of mental illness. It is actively involved in consultancy work and mental health training. It belongs within an umbrella organisation that is made of a Board of Directors (including those with mental health problems) and has two advisory groups. Importantly, it is run by individuals with personal experience of mental illness which has allowed them to identify and relate to the needs of service users ‘from the inside’. The organisation has three paid staff, along with several volunteers (members are also encouraged to be active within the organisation if they want to) and staff are encouraged to take training whenever possible (e.g. diversity training, equality training and mental health crisis training). Currently there are 470 members and thirteen local branches located throughout the Highlands. In terms of links with formal mental health services, the organisation maintains some links with teams in each area.

The final organisation in Highland (Site C, Highland) was started approximately 10 years ago and provides on-going support for members seven days a week. The organisation is primarily funded through Local Authority Social Work. The organisation operates across two sites in the Highlands with the aim of providing a community resource for those who are experiencing isolation, loneliness or boredom as a result of mental ill-health. Currently there are nine paid staff and several volunteers. The organisation has developed positive informal working relationships with the local Community Mental Health Team as a way of providing more joined-up care for members.

In Alberta, one of the organisations (Site D, Canada) was part of a large, national organisation (NGO) which was started in 1988. Initially, the support provided by the
organisation centred on long-term accommodation for service users which eventually developed to offering individualised services in the planning and development of their support. In 1992 the organisation opened its drop-in centre to provide individuals with opportunities to participate in activities and to receive assistance to maintain social, physical and emotional wellbeing. Core programs provided by the organisation include Assertive Outreach Support (helping to reach the immediate needs of service users that other services cannot reach), Independent Living Supports (to assist individuals to find meaningful ways of participating in the community), Counselling Services, a residential program and two Consumer Initiatives (‘Cooking with Class’ and ‘Speakers Group’). The organisation has mandatory training requirements (First Aid and CPR, Non-Violent Crisis Intervention, Mental Health First Aid and Applied Suicide Intervention Skills Training) for staff and volunteers (n-20) and there are funds available for training opportunities that staff may be individually interested in. The organisation is funded through Alberta Health Services, and through various grants and fundraising.

The organisation works with various community partners such as the mental health clinic, the addictions clinic and the psychiatric unit at the local hospital in order to streamline services and avoid duplication. In particular, training opportunities are shared with professionals from those other services. The organisation also meets with formal mental health services in relation to case consultations and to exchange knowledge about new initiatives and research.

The final two organisations (Site E and F, Canada) that took part in the study were part of the international Clubhouse model. The first Clubhouse originated in New York in 1948 and was founded on the premise that people with mental health problems could work productively and have socially satisfying lives in spite of their mental illness. Within this framework, therefore, people who use the service are conceived as ‘members’ who work side-by-side with staff to manage all the operations of the Clubhouse (referred to as a work-ordered day). In particular, contributing to the daily running of the group in partnership with staff provides members with the opportunity to contribute in significant and meaningful ways. Each local branch of the Clubhouse organisation operates on a number of standards such as the provision of Transitional Employment Placements (TEPs) that provide members with opportunities to obtain paid employment in the local labour market. The local branches also assist members in accessing community-based educational resources and also assist in securing adequate housing. A further dimension

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12 There are currently over 300 Clubhouses worldwide since 1989
to the model is that each local branch provides evening and weekend social and recreational events to ensure members have maximum opportunities to participate. In terms of links with other community mental health services, the Clubhouse model aims to complement available psychiatric treatment by forging links with local mental health professionals as part of its collaborative approach. In addition, Clubhouse International provides a range of mental health training courses for staff within the local branches in order to promote the growth and development of the model.

3.6 Participants

3.6.1 Service Users

The focus of the current study is on mental health service provision in remote and rural areas, in terms of those who use them and those who provide them as part of their professional remit. As previously noted, a further dimension is to explore the role of rural voluntary organisations in terms of service provision.

According to Barbour (2008) groups are usually convened ‘on the basis of some shared attribute, such as professional role, or locality. Members may also be recruited on the basis of some shared experience, such as having a specific chronic illness’ (p. 135). For the purposes of the current research, it was felt that the most appropriate participants (in terms of service users) for the study would be those who were currently attending, or have attended, voluntary organisations in connection with mental health problems.

3.6.1 Definition of Service User Population

For the purposes of the study, the population (in relation to service users) was defined as all adult service users, aged 18 or over, who are currently, or have used, mental health services in remote and rural areas.

**Inclusion Criteria**

1. People over the age of 18
2. Individuals who have had or still do have a mental health problem

**Exclusion Criteria**
1. People under the age of 18
2. Participants who could not give informed consent
3. Individuals who were suffering from severe forms of mental illness (that required hospitalisation)
4. Those who did not have any contact with mental health services

Whilst the research did not record the diagnoses of participants, it was noted during informal discussions with the managers that diagnoses of members ranged from depression through to more serious manifestations of mental ill-health such as paranoid schizophrenia.

3.6.2 Service Providers

In terms of service providers, participants were recruited based on the criteria that they were providing mental health services in remote and rural areas. In particular, the research aimed to capture the experience of professionals working for statutory services (i.e. Community Mental Health Teams), in private practice and in the voluntary sector (see Table 2). Capturing the views of professionals from different sectors offered the opportunity to consider whether the challenges of delivering mental health services in rural areas were the same.

Table 2: Service Providers by Occupation and Sector

<table>
<thead>
<tr>
<th>Country</th>
<th>Profession</th>
<th>Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>Occupation Therapist (OT)</td>
<td>Statutory</td>
</tr>
<tr>
<td></td>
<td>Mental Health Officer (MHO)</td>
<td>Statutory</td>
</tr>
<tr>
<td></td>
<td>Community Psychiatric Nurse (CPN)</td>
<td>Statutory</td>
</tr>
<tr>
<td></td>
<td>Regional Manager</td>
<td>Voluntary</td>
</tr>
<tr>
<td>Canada</td>
<td>Psychologist</td>
<td>Private</td>
</tr>
<tr>
<td></td>
<td>Intake Co-ordinator</td>
<td>Statutory</td>
</tr>
<tr>
<td></td>
<td>Counsellor</td>
<td>Private</td>
</tr>
</tbody>
</table>
3.6.3 Recruitment of participants (purposive sampling)

3.6.4 Service Users

The study used purposive sampling (also known as judgement sample) in terms of recruiting participants to the study. This form of sampling involves the researcher actively selecting potentially the most productive sample to answer the research question (Marshall (1996)). It is a more intellectual strategy than the simple demographic stratification of epidemiological studies (although managers of each voluntary group aimed to include demographic diversity in the participants they approached to take part) in that it aimed to recruit subjects who had specific experiences and special expertise.

Voluntary groups were identified for the research based on an initial search of the internet and what was currently available in the public domain (using the search engine ‘Google’). Search words included ‘Community Mental Health Drop-In Centres’ ‘Community Mental Health Voluntary Groups’, and ‘Service User Groups’. Each term was prefixed with rural Highland or rural Alberta. Once suitable organisations were identified, the manager of the local branch was then approached by email and then letter with details of the study. If willing to take part, the manager was asked to identify and approach five service users to consider taking part in the research (due to ethical considerations and confidentiality, it was felt more appropriate that the manager identified those service users who they felt may wish to take part in the focus group discussions).

In Scotland, managers were issued with a letter to give to each participant, an Information Sheet Guide and a Consent Form for participants to sign. A stamped addressed envelope was also included for participants to return their Consent Forms. Once forms were returned, each manager was contacted again to arrange a suitable date to carry out the focus group. In Canada, managers were sent a combined Information Sheet Guide/Consent form. The forms were signed and collected on the day of the research.

To ensure convenience for service user participants, the focus groups were carried out in the building in which each voluntary group was run. Each focus group took place in a private room, where the discussion could not be overheard. No participants were paid to take part in the research. In accordance with ethical requirements, the researcher ensured
participants were comfortable at all times throughout the discussion, and that staff members were close by.

### 3.6.5 Service Providers

In Scotland, an initial search of the Highland Council website was made in order to find rural professionals within Community Mental Health Teams to contact about the research. In Canada, an initial search was made of the Government of Alberta Programs and Services website and also the Alberta Health Services website. Once professionals were identified, initial contact was made via email informing them of what the study was about. After agreement had been given, each provider in Highland was sent an Information Sheet along with a Consent Form and in Canada a combined Information Sheet/Consent Form was issued. Consent forms were signed and collected on the day of the research.

To ensure convenience for service provider participants, the interviews were carried out at the workplace of each professional, except in once instance, where the interview took place at their home.

### 3.7 Methods

#### 3.7.1 Focus Groups

Qualitative research encompasses multiple data collection methods. As previously outlined, this thesis uses the qualitative methods of focus groups and individual interviews. Using focus groups as a means of collecting data has been widely used in health service research since the late 1980s (Lucock 2007). For the current study, it was felt to be useful as it allowed the perspectives, feelings and experiences of service users themselves to be heard: a critical component for informing evidence-based practice (Andonian 2008). Using focus groups also enabled the research to capture the processes whereby social knowledge is collectively produced (Neal & Walters 2006). As Powell and colleagues suggest, focus group discussions allow participants to ‘ascertain the cognitive rationale that determines why they hold those attitudes and why they behave in the way they do. In short, the focus group contextualises human phenomena within the personal and social milieu within which it arises’ (Powell et al., 1996, p. 196). In terms of the current research, such contextualisation was important not only in terms of mental
health service provision but also in terms of rurality; in other words, what did it mean for participants to use mental health services in remote and rural areas. There are a number of common challenges that many rural dwellers face (see Chapter 2), most notably in terms of accessibility and availability of services. In the context of mental health, there are additional elements for those who use mental health services, such as high visibility and stigma, which are tied in with rural culture. Through group discussion and interaction it allowed for an exploration of these factors. Moreover, given the pivotal role of the voluntary sector in rural areas (see p. 51) it allowed for an exploration of the role voluntary services play in the lives of participants and how they interpret that meaning.

Alternative methods, such as individual interviews, could have been used but this would not have allowed for an understanding of how collective social knowledge was produced within a network. Personal attitudes, feelings and beliefs may be partially independent of a group or its social setting but they are more likely to be revealed via the social gathering and the interaction with others in the group (Gibbs 1997). Given the vulnerable nature of participants, it was also felt that sharing their views in a group would allow them to express their views in a safe and supportive environment (Powell et al., 1996 Owen 2001). In this instance, focus groups provided an opportunity for deeper insights to emerge based on the interactions between participants themselves and how they construed meaning. This was particularly significant in relation to understanding concepts such as ‘social inclusion’ and ‘social exclusion’ which are widely contested terms. Moreover it was appropriate to consider how they were interpreted at a micro level in order to assess their usefulness at policy level. Focus groups, therefore, provided an excellent opportunity to do this. Using focus groups in different locations also allowed the researcher to ascertain whether there were trends or similarities in the experience of service users in rural areas, or, if in fact there were regional/international differences.

3.7.2 Focus Group Procedure

The schedule of questions was employed as a framework to guide each group towards discussion of topics that were relevant to the research focus (see Appendix 1). The aims of the thesis and research questions were the basis for the generation of the focus group question schedule. Aside from the interview schedule and occasional prompts, the aim was for minimal involvement by the researcher in order to allow participants to share their experiences spontaneously and with as little direction on the part of the observer as
The intention was to encourage dialogue primarily with other members of the group rather than with the researcher. Occasionally the researcher took a more active and direct role when more dominant members of the group appeared likely to obscure another’s input or when it seemed that others required a more direct invitation to contribute to the conversation. However, there was no pressure placed on participants to speak if they did not want to or if they felt uncomfortable in any way. The focus group sessions lasted from one to one and a half hours and were recorded using an electronic recording device.

### 3.7.3 Composition of groups

The current study used small focus groups. In Highland one focus group had six participants (Lower Highland), one group had four participants (Western Highland) and the final group had five (Northern Highland). Total number of Highland participants was 15. In Alberta, one focus group had four participants (Northern Alberta) and the other two groups (Northern Alberta and Southern Alberta) each had five participants. Total number of Canadian participants was 14. It was felt that smaller groups would be more useful given that larger groups for social science research can prove too unwieldy due to the type and content of interaction (Barbour 2008). Using a small focus group also made it easier to identify who was speaking when it came to transcribing the data.

Given the international comparative element in the research design, it was anticipated that holding focus group discussions in both Scotland and Canada would potentially yield significant amounts of detailed and lengthy data. As such, it was felt three groups in each location (six focus groups in total) would be suitable for the study. It was felt this number would allow for sufficient views to reach data saturation.

### 3.7.4 Semi-Structured Interviews (Service Providers)

The research also used semi-structured interviewing to explore the views of service providers (see Appendix 2). This approach not only allows greater flexibility than structured interviewing but also allows the researcher to potentially explore unknown issues that may be brought up by participants themselves (Barbour 2008). Semi-structured interviewing as a method for collecting data is also suitable as it places emphasis on how the interviewees frame and understand issues and events (Bryman...
The need to explore the views of mental health service providers is accurately summed up by Powell and colleagues (1996), as they note,

‘...it is important to investigate the views of front-line workers....who provide mental health services, as it is to study the views of those who receive them. A client satisfaction survey may indicate that existing mental health services are fulfilling all the physical and social needs of the service user. If the services being provided to the clients are being done at the expense of the health of the front-line workers, however, their viability is seriously undermined. High rates of staff burn-out invariably result in high rates of staff turnover. In an area of health service provision….where the strength and continuity of the relationship developed between the client and the formal carer is central to the success of the programme, such fragmentation in service delivery can only be to the detriment of service users’ (p. 194).

The use of semi-structured interviews has become the most prevalent tool in research exploring life events and psychotic illness (Fallon 2008). It has also been used to explore schizophrenic patients’ beliefs of wellness (Hamera et al., 1994). Using semi-structured interviews to explore the concept of recovery, Piat et al. (2009) were also able to uncover contrasting views of its meaning by service users. This method has also informed the work of Parr and colleagues (2004) and their important contribution to mental health research in rural areas. Additionally, researchers in Australia exploring rural adolescents’ experiences of accessing help for a mental health problem (Boyd et al., 2007) found that by using semi-structured interviews, they were able to uncover a number of challenges for young people that were unique to rural communities (i.e. social visibility, lack of anonymity, a culture of self-reliance, and social stigma).

Using the interview method is relevant to the current study because a one-to-one method offers greater anonymity and confidentiality, thereby allowing the participant more freedom in how they choose to respond to the question: a focus group discussion could potentially inhibit responses due to professional etiquette. The aim of talking to providers is twofold; to elicit what, if any, are the challenges that they face in delivering mental health services in remote and rural areas (within the context of social inclusion), and, to assess how well they feel services work together to ensure ‘good quality mental
health services for everyone that needs them’ (Scottish Government 2010b). A semi-structured interview, therefore, provides greater flexibility in the process and allows the researcher to ask further questions in response to any significant replies (Bryman 2004).

Nevertheless, as part of the research process it is important to acknowledge any limitations that come with incorporating semi-structured interviews as part of the research design. As noted by Boyd et al. (2007) the results cannot be used as a comparison within other contexts. Also, unstructured interviews can allow participants to describe their experiences in greater detail than semi-structured interviews (Gibson 1998). Moreover, unstructured interviews provide a greater range of data (Norman & Parker 1990). However, unstructured interviews can also produce vague statements that are difficult to interpret (Hamera et al., 1994).

3.7.5 Semi-structured Interview and Focus Group Guide

The focus group schedule was developed based on specific topics identified in the literature review. Nevertheless, it was decided not to pilot the schedule or to have it reviewed prior to beginning empirical work. Instead, the aim was to adopt an iterative approach thereby making data collection flexible. In particular, it was decided that amendments or additions to the schedule would be done based on what emerged from the first focus group. For example, if it was found that the discussion did not centre enough on the rural dynamic, then this would be a main driver for the next focus group.

3.7.6 Transcription of the data

The audio recordings were uploaded on to a secure network server, to a file only accessible by the researcher and supervisor. Transcripts were typed by the researcher shortly after each focus group had finished. This was particularly helpful in order to ascertain who was speaking given the challenge of identifying individual speakers (Kitzinger & Barbour 1999). The focus group members were simply referred to as ‘Male’ or ‘Female’ to preserve anonymity and geographical location was referred to as, for example, ‘North Highland’. Where extracts of conversation have been included, speakers were referred to as, for example, ‘Participant 1’. Where participants had started to say something but had been interrupted, had paused, or chose not to finish what they were saying, this was indicated in the transcripts by using rounded brackets (…) within
the text. Service provider participants were referred to in terms of their job title and location, for example, ‘Occupational Therapist, Highland’.

3.7.7 Ethical Issues

As previously noted, focus groups have increasingly been promoted as a useful method for obtaining the views of service users, caregivers and service providers about health services (Owen 2001). However, working with vulnerable groups also brings with it ethical issues that have to be considered. Discussing an experience of exclusion and isolation may cause discomfort or embarrassment to the service user. Nevertheless, whilst some consider group work inappropriate for very sensitive topics, it can also be argued that people may be more willing to talk openly about issues when in a group of people with similar experiences (Kitzinger & Farquhar 1999). As a consequence, however, it can lead to new information being disclosed to the group by the service user. As Barbour (2008) highlights, ‘….careful thought should be given to the implications of utilizing pre-existing networks….since the discussion, and any revelations made by the individuals, may well impact on future relationships’ (p. 134). Nevertheless, despite these ethical implications, Kitzinger (2005) asserts ‘I have yet to see a research question where focus groups in some form would not be relevant, even if other data collection techniques are also used’ (p. 58).

This thesis aimed to explore how well mental health services meet the needs of rural service users and whether they facilitated inclusion. It was, therefore, imperative to listen to the views of service users. Additionally, whilst subjects such as social exclusion or stigma may be difficult for some to discuss, focus groups provide flexibility in that not everyone has to respond if they do not wish to. Focus groups also ensure that ‘difficult’ topics can be discussed with others in a similar position, or ‘safety in numbers’ (Barbour 2008).

In discussing sound ethical guidelines for conducting social science research, Christians (2000) notes that, ‘research subjects have the right to be informed about the nature and consequences of experiments in which they are involved. Proper respect for human freedom generally includes two necessary conditions. Subjects must agree voluntarily to participate [and] their agreement must be based on full and open information’ (p. 138). In order to ensure such ethical considerations were strictly adhered to, the current research only included participants who were over the age of 18, who were not acute or
suffering from more severe forms of mental illness (that required hospitalisation) and only included those who could give informed consent. Each participant was also given a full information guide informing them exactly what the research was about and were informed they could leave the research at any time should they choose.

In terms of privacy and confidentiality Christians (2000) also notes that, ‘Confidentiality must be assured as the primary safeguard against unwanted exposure. All personal data ought to be secured or concealed and made public only behind a shield of anonymity’ (Christians 2000, p. 139). In line with this, the research upholds the rights and liberties of those participants who took part and ensured confidentiality throughout. All participants, communities, areas and groups remain un-named, with no identifying information given in any of the chapters of this thesis. In addition, all personal data was stored within a locked cabinet located within the researcher’s department and all data transcripts were analysed on a secure server. Participants were also provided with an overall summary of the research findings at the end of the process.

3.7.8 Ethical Approval

In order to comply with ethical guidelines, an application was made to the North of Scotland Research Ethics Committee (NOSREC). Ethical Approval was granted by the Committee for all work carried out in Scotland in relation to both service users and service providers. For Alberta, ethical approval was granted by the Conjoint Health Research Ethics Board (CHREB). Ethical approval covered both service users and service providers.

3.8 Data Analysis

3.8.1 Theoretical Position

In terms of qualitative data analysis, there are various approaches that are used. Miles and Huberman (1994) cite three of these approaches; namely, interpretivism, social anthropology and collaborative social research, whilst Bryman (2004) narrows this to analytic induction and grounded theory. For the purposes of rigour, the current study makes its theoretical position explicit for data analysis, and aligns itself with the tenets of grounded theory. In particular, with the notion that it is concerned with the development of theory out of data, and that the approach is iterative.
Nevertheless, there is considerable controversy about what grounded theory is and entails (Charmaz 2000). Some writers have observed that studies published as ‘grounded theory’ for their data collection and analysis are unclear and inaccurate (Locke 1996). More specifically, it would seem that rigid adherence to such a method is questionable. In their paper, Johnson and colleagues (2001) note that in terms of developing ‘theoretical sensitivity’, even Glaser and Strauss in their earlier work on dying in health institutions, admit to being interested in communication with the dying as a result of personal experiences. In this way, Johnson et al. suggest that published studies are generally carried out with greater or lesser emphasis on the approach documented by Glaser and Strauss (1967). As they suggest, ‘the best evidence that there is no such thing as the ‘right way’ to do grounded theory comes from the authors themselves’ (referring to later theoretical differences between the two theorists).

A key feature of grounded theory is the recursive, process-oriented and analytic procedure (Locke 1996). The overlapping nature of data collection, coding and interpretation are vital in the quest for theory. However, one’s own interpretation of a remark, or what is ‘noticeable’, during the coding stage suggests that the conceptual base from which the researcher is approaching the field cannot be ignored; it has a part to play in terms of the emerging picture that is derived from the data. As Miles and Huberman note, ‘What may be generated as ‘data’ is affected by what the ethnographer can treat as ‘writable’ and ‘readable’. Similarly, transcription of tapes can be done in many ways that will produce rather different texts’ (Miles & Huberman 1994, p. 9). The idea that extant theory should be avoided in the quest for new discoveries, has led to the idea that the researcher should enter the field with a ‘blank agenda’ (Goulding 1999). Nevertheless, drawing from Glaser’s own work, Goulding illustrates the role existing theory has in sensitising the researcher to the conceptual significance of emerging concepts that arise from the data. In this way, ‘knowledge and theory are inextricably interlinked and should be used as if they were another informant. This is vital, for without this grounding in extant knowledge, pattern recognition would be limited to the obvious and the superficial, depriving the analyst of the conceptual leverage from which to develop theory’ (Goulding 1999, p. 6).

Selectivity in terms of data analysis is unavoidable given that it is carried out by human beings. However, as argued by LeCompte (2000) awareness is the key. In particular, tacit and formative theories can influence the process in many ways. In terms of the former, the author suggests tacit theories guide behaviour based on a priori reasoning.
(e.g. choosing to carry an umbrella on a cloudy day). More importantly, for data analysis, such internal influence can create bias in the investigation. Formative theories are more formal and generally emerge from the disciplines from which the researcher is trained. They help to develop research questions and to guide the collection and analysis of data. According to the author, researchers must make both clear in the process.

The current study aims to identify any potential for bias by providing a reflexive section (see below), in which issues such as positionality, including the researchers own background, are made clear. A more nuanced account can potentially enhance the methodological process as it opens up the researchers account ‘to scrutiny and interrogation’, ultimately making the findings more robust (Pini 2004). Furthermore, by providing a reflexive account, it allows for increased awareness and understanding of the role of the researcher’s biography and the values that underpin their analysis (Gewirtz & Cribb 2006).

3.8.2 Reflexive Statement

This research journey has been a deeply personal one for a number of reasons. During two phases of my life, I have experienced depression which required medication. Whilst depression is certainly less severe than the mind-altering states of psychosis, these depressive phases allowed me some understanding of what it means to feel out of control and with no hope for the future. In my role as researcher I positioned myself as one who had absolute respect for all participants and the stories that they shared with me. I was always conscious that it is a generous act on the part of a participant to allow a researcher (stranger) to ask questions and gather information about their life. My aim was never to judge those stories and, indeed, I would make a point at some stage during the discussions with participants to also let them know that I had been treated for depression, in order to remove any sense of unequal power relations (researcher versus subject matter). I consciously sought to treat all participants from a stance of neutral but positive regard. In order to maintain this neutrality, I would regularly discuss the findings and thematic interpretations with my supervisors.

In keeping with the researcher’s intention to disseminate the findings, written feedback on the findings have been given to the focus group participants in the form of a written document. In addition, one organisation in the study, who were actively involved in
representing service users throughout the Highland, were sent a series of major excerpts from draft chapters of this thesis on issues of interest to them.

Doing qualitative research is by nature a reflective process given that the construction of knowledge takes place in the world and not apart from it. Thus, reflexivity requires being honest and ethically mature in research practice (Hughes 2006). Since embarking upon this journey, it has changed me a great deal. Whilst hearing first-hand accounts of those with mental health problems gave me a renewed appreciation for the daily battle faced by service users, and of the way in which life really can be turned upside down in the blink of an eye, it also taught me about resilience and the strength of the human spirit. It gave me a renewed understanding of the extreme ways in which the vulnerable aspects of our human nature, the parts that can be kept so well hidden by ‘normal’ people, can be so violently forced out and laid bare for all to see for service users. A sense of shame and guilt was often conveyed by participants in relation to being exposed in this way, giving me greater appreciation for what it means to be courageous.

When I started this journey, I lacked confidence in my ability to undertake a PhD. However, as this thesis has progressed, my belief in myself and my ability has changed considerably. This journey, therefore, has been one of personal growth, empowerment and achievement.

3.8.3 Recovery: Empirical Challenges

Chapter Six of this thesis focuses on the way in which the rural voluntary organisations that took part in this research promote and facilitate recovery for their members. As outlined in Chapter Two however, there are a number of issues with the concept of recovery as a process given that it is intuitive and highly subjective. Moreover, its semantic ambiguity runs the risk of it becoming meaningless in academic research (Rudnick 2012a). This thesis acknowledges the empirical challenge of identifying if, or how, the process of recovery is being promoted and facilitated. Whilst the validity of the findings stems from the personal testimonies of participants in this study, there is corroborating evidence in support of these assertions that is worthy of consideration. For example, the annual report of one (Highland) voluntary organisation that took part states, ‘The true benefits of our service have always been hard to quantify. Although difficult to evidence, we are confident that we have prevented hospital admissions and even saved lives. We have also greatly enhanced the quality of life of many more people’ (Western
Highland Voluntary Organisation 2013, personal communication). In terms of the Clubhouse model, the fundamental framework is about providing ‘the right to meaningful relationships [and] the right to meaningful work’ and ‘a place where people with serious mental illness…participate in their own recovery process by working and socializing together in a safe and welcoming environment’ (http://www.iccd.org/). In personal correspondence with each of these organisations, it was repeatedly noted that members had achieved stability through routine and a sense of belonging. In terms of evidence around reduced reliance on services, resumption of a more normal way of life or reduced rates of re-referral to services, most of the voluntary organisations reported that there had been fewer hospital admissions for members due to early intervention by staff (i.e. picking up on early signs of illness). When a hospital stay had occurred, one Canadian organisation found that the duration was shorter due to the support available when members were discharged. Recovery-orientated practice is still currently being rolled out across Scotland, therefore, official indicators are treated with caution here. However, such evidence is important to note given the empirical challenges with recovery noted earlier.

Whilst this supporting evidence is important, this thesis aligns itself with the idea that recovery is a deeply personal process tied to concepts such as hope, healing, personal growth and the ability to develop new meaning and purpose in life. In this way, a positive subjective mental state, or the relationship service users have with their own mental health problem, is the most important aspect irrespective of externalities such as decreased reliance on acute hospital services. Whilst objective evidence of a transition from one kind of behaviour to another is important given the conceptual challenges of recovery as a process, this thesis aligns itself with the view that feeling better is getting better regardless of objective, quantifiable evidence in relation to formal service utilisation.

3.8.4 Process of Data Analysis: Thematic Analysis

The conceptual framework was informed by a number of paradigms around mental health. In particular, ideas around social inclusion, social capital, and voluntary sector discourse were prominent themes within the literature review. Forming a structure around such ideas led to the formulation of key research questions for the study:

- Research Question 1: What does it mean to experience mental health problems in remote and rural areas?
• Research Question 2: What are the challenges that service providers face in remote and rural areas?

• Research Question 3: What benefits are there for service users attending voluntary groups in remote and rural areas?

• Research Question 4: Do voluntary groups offer something that other rural mental health services do not?

• Research Question 5: Is social capital useful for understanding the benefits and role of mental health voluntary organisations in a rural setting?

Thus, the process was driven by the research questions (framework) and involved continual data reduction: reducing the data allowed for key themes and underlying patterns to emerge. This ensured the data was transformed thereby reflecting the ‘meanings and assumptions’ that participants attributed to the social world around them (Miles & Huberman 1994).

3.8.5 First stage of analysis

Developing an accurate portrayal of a specific case within qualitative data analysis is only possible through coding the data, using both open and closed coding (LeCompte 2000). All transcripts were uploaded into N-Vivo software (N-Vivo version 9). An initial coding framework involved approaching the data using an open coding method. This helped with early concept development (LeCompte 1999) and ensured that any interesting remarks or observations were noted without being grounded in a familiarity with the data. Any themes that were discernible were noted at this stage and referred to once the later closed coding was completed. This analysis was in part informed by and guided by Bryman (2004) who advises the initial open coded technique in order to highlight comments that may have theoretical significance and/or are salient within the social worlds of those being studied.

3.8.6 Second stage of analysis

The transcripts were then read many times and subjected to a thematic analysis. The codes from the first stage of analysis were also referred to and included in the second stage of analysis. The closed coding initially consisted of the actual place where the fieldwork was conducted. Closed coding was then driven by the research questions (i.e.
looking at what participants said and the underlying meaning in terms of existing knowledge/theory) and was used to develop a clear framework for emerging concepts and theories. The analytical concepts of ‘social inclusion’, ‘social capital’ and ‘recovery’ were important for theoretical interpretation of the themes (as outlined in previous chapters). Initially the coding aimed to be little more than descriptive but eventually filtering the data to allow the coding to become inferential through the identification of themes. In this way the codes were formalised by identifying a specific code word for each emerging theme. Each area of the transcripts identified in the ‘open coding’ stage were also given their formalised label. Closed coding categories in the framework were based on the following criteria: inclusive (i.e. they reflected a range of content in the data), useful (i.e. they reflected a meaningful connection to the data), and were clear and specific (Bryman 2004).

The project adopted an iterative position, which required repeatedly engaging with the data in a systematic way. Searching for meaning and recurring incidents within the data, through repeated engagement, ensured that any such meanings could be tested for their ‘plausibility, their sturdiness, their ‘confirmability’…their validity’ (Miles & Huberman 1994, p. 11). It was hoped this process of refinement would encourage confidence in the final report and recommendations. Additionally, emphasis on the iterative nature of the process meant that analysis started after the first focus group had been carried out. By implication, this meant that the initial analysis shaped the next steps in the data collection process (Bryman 2004).

3.9 Chapter Summary of Methodology

Whilst there are advantages to both quantitative and qualitative methods in mental health research, scientific debate needs to move beyond the dialectic of quantitative versus qualitative research, to recognise the merit of a variety of approaches. McVilly et al. (2008) suggest the issue is which design best addresses the research question. The research questions which comprise this thesis focus on assessing how well community-based mental health services meet the needs of those they are intended for, within the context of social inclusion.

To achieve these aims, therefore, qualitative methods were considered most appropriate. For example, the interactions between participants in the focus group discussions offers insights into how meaning is constructed; in other words, it offers the opportunity for service users to consider what it means to experience a mental health problem and to use
appropriate services, in comparison to others. In addition, focus groups can ‘encourage participants to collectively address topics to which, as individuals, they may have previously devoted little attention’ (Barbour 2008, p. 134). Using a focus group method is therefore suitable to the research design because it allows for an in-depth understanding of how everyday meaning is constructed (Bloor et al., 2001) for service users in relation to the spaces (i.e. rural, voluntary organisation) which they occupy. It allows the research to capture how service users interpret this experience at a micro level in order to assess how accurately such experiences are aligned with current policy developments.

The research also uses individual interviews to examine what some of the issues are in relation to delivering mental health services in remote and rural locations. As noted earlier, investigating mental health issues within a rural context has largely been neglected within academia and therefore investigation is long overdue. Using semi-structured interviews ensured that key issues were addressed whilst also allowing participants flexibility to address issues unanticipated by the researcher. For example, the study was keen to explore the issue of how well services engage with those who are reluctant to access services in rural areas. Whilst the response could have been straightforward, it uncovered issues relating to resource constraints that were beyond the control of frontline workers, regardless of their good intentions.

Finally, a key element to the research involved an international comparison with Alberta. International research can contribute to a deeper understanding of the socio-cultural practices of other societies. Such comparisons can also offer new insights into existing practices and can potentially highlight gaps in knowledge. For the purposes of the current study, it is hoped that the findings will contribute to existing international comparative research.

Researching the Highlands of Scotland and rural Alberta offers a unique opportunity to explore points of convergence and divergence between both countries within the context of rural mental health. As noted in the previous chapters, rural mental health research remains largely absent from the knowledge base in both countries. In addition, rural voluntary sector organisations are heavily relied upon to fill the gap left by formal services. Exploring these factors, therefore, allows for a better understanding of what contribution mental health voluntary organisations play within remote and rural areas for service users.
In the following chapter (Chapter 4), the data presented is in relation to research question one. Data in relation to research question two is presented in Chapter Five. Chapter Six centres on research questions three and four. Finally, the data framed around research question five is presented in Chapter Seven.
CHAPTER 4

MENTAL HEALTH: THE RURAL EXPERIENCE
4.1 Understanding the Rural Experience of Mental Health

Understanding the rural environment and how it impacts on the experience of mental health service users is central to this thesis. As highlighted by the literature review (Chapter 2), the voices of rural service users have largely been ignored within the mental health research landscape. It is, therefore, important to present an analysis of the focus group discussions with Highland and Canadian service users in relation to rurality, thereby setting the scene and providing context for Chapters Five, Six and Seven. The aim of this chapter is to understand what it means to be situated in a rural community as a service user, and the processes that lead to social exclusion or inclusion for those with a mental health status and hence answer research question one ‘What does it mean to experience mental health problems in remote and rural areas?’. Data from the service provider interviews is also included in order to provide a more comprehensive picture of rural mental health.

4.2 Context of Rural Life

There are a number of challenges to comparing rural environments given how much they differ around the world. As Nicholson (2008) notes, the experience of a crofter living on a remote Scottish island may differ significantly to that of a commuter in Essex. Furthermore, cross-nationally, what may be considered rural or remote in one country may be understood quite differently in another. In Canada, for example, some remote communities are defined as those without year-round road access, or which rely on airplanes or trains for transportation to a larger centre (Rural and Northern Health Care Panel, undated). To study and compare rural areas in the context of mental health is a further complex undertaking. Chapter Two of this thesis presents data which demonstrates how geographical factors such as remoteness and the small scale of rural communities impact directly on the level of service provision. However, there are other factors that need to be considered. As outlined in Chapter Three, the Highlands of Scotland are sparsely populated (compared to most other rural communities in Britain and, indeed, much of Europe). Nevertheless, whilst such geographical factors are important per se, there are historical and cultural influences that also make the area unique. There are substantial differences, for example, between rural villages in Cornwall (populated disproportionately by retired incomers), and those of Highland where the same families have often lived for many generations. This raises questions about the influence of the human environment on individual senses of identity and the capacity of a person to change/adapt in response to new experiences. In contrasting life
in a city and life in a Sutherland village, it is arguable that in the former, most interactions are likely to be between people who know little or nothing about one another. Opportunities for an individual to present and develop aspects of their personality according to the company they choose to keep are potentially far greater in urban contexts than in small, traditional communities where their role and identity is constantly reinforced by longstanding, even intergenerational, face to face familiarity. These factors are of considerable importance in relation to issues like the stigma of mental illness and its relative inescapability.

Moreover, there are considerable differences between settlements in the Highlands. The crofting villages of the Western Isles, and the significant influence of the church in local cultural life, stands in contrast to the more populated settlements of the east coast. Even between the islands there are distinct cultural differences. As Grant (1977) observes, ‘Although the villagers of Lewis and the villages of Skye have much in common, it is still possible to trace in their attitudes subtle differences […] which almost certainly derive from the fact that Skye enjoys a continuity of clan history, disturbed and sullied at times, but still unbroken’ (p. 53).

By contrast, the Canadian settlements used in this research are of much more recent origin than the Highland ones. These communities emerged around the turn of the last century, during a time of great industrial development and wealth in Canada. Whilst the economy was being transformed, Canada was also altering its society and culture, encouraging immigration from around the world (Bumsted 1998), making Canada essentially a ‘multitude of societies’ (Conrad et al., 1993, p. 608). The implication here is that the Canadian communities are potentially more heterogeneous in cultural and religious terms, with less historically entrenched beliefs and prejudices. In the context of mental health such factors may be particularly important in relation to tolerance of difference.

Indeed, Canada’s defining characteristic is arguably its ability to host a broad diversity of cultures and peoples, reflected in legislative acts such as the Canadian Multiculturalism Act (1988). Fundamental to this is the notion that all citizens are equal and should have a sense of belonging and security through mutual respect: ‘through multiculturalism, Canada recognises the potential of all Canadians, encouraging them to integrate into their society and take an active part in its social, cultural, economic and political affairs’
In line with this, the first national survey to explore what it means to be a Canadian citizen recently found that having a sense of social responsibility was important for Canadians, particularly in relation to active community participation and through tolerating others who are different (Citizenship and Immigration Canada 2012). Other studies that have explored community belonging found that almost two-thirds of Canadians (64%) reported a strong sense of community belonging, with people living in rural environments more likely to report a somewhat/very strong sense of community belonging (Shields 2008). (However, there were variations between the provinces with Alberta and Quebec reporting a lower sense of community belonging than Canadians overall).

The sheer size of the landmass is also significant in terms of contextualising rural Canada. Rural communities in Canada often have fewer resources and inhabitants have to travel considerable distances to access social and medical services (Lunsky et al., 2007). In terms of mental health service provision, the picture is rather poor. Many rural communities lack even a basic level of support:

> ‘[in Canada] what actually exists is an array of often under-funded programs and services that have been developed at different times and at every level of government […] In northern, rural, remote and other underserviced areas of the country, these challenges are often compounded by isolation, higher cost of service provision, complex social and jurisdictional issues, and cultural diversity’ (Mental Health Commission of Canada 2009a, p. 69).

Indeed, one participant in the current study recounted a story of becoming acutely unwell some years previously and having to travel over 300 miles to the closest psychiatric in-patient unit (accompanied by the local doctor’s wife) demonstrating the challenge of service provision within such a large geographical area. Whilst the Canadian localities used in the study provided some level of mental health services, they were all located approximately 60 minutes’ drive time from larger settlements.

The above observations are important to note in order to contextualise and ground the data in this chapter:

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13 the policy of multiculturalism replaced earlier government policies that centred on integration for migrants, Mann 2012
Analysis of the data from service users and service providers is presented with reference to existing literature to advance understanding of living with mental health issues in remote and rural areas.

Participant discussions on what it means to experience mental health problems in rural areas have been organised into three overarching themes, each with corresponding subthemes. Each theme highlights a different aspect to rural mental health. The first theme presented starts from the individual standpoint in relation to stigma within the context of experiencing mental health problems in rural areas (Theme 1). This subject formed a major part of the focus group discussions. Its importance for service users is therefore reflected by its prominence as a starting point for the chapter. Theme Two explores some of the complex, and often contradictory, ways participants conceive of rural places; in particular as a motivational factor in relation to migration (i.e. seeking a better life or better mental health resources). Following from this, Theme Three presents an analysis of participant narratives to highlight the disjuncture between social inclusion policy and the lived experience of mental health service users in rural areas.

4.3 Theme 1: Stigma

The theme of stigma covers a number of issues, or sub-themes under this central heading. Its defining elements centre around participants’ experiences of stigma (both direct and indirect) and reflect prevailing ideas in the wider literature, most notably the notion of mental illness as a discrediting attribute (Goffman 1963), one that involves stereotyping and separating (‘us’) from the stigmatised group (‘them’) (Corrigan & Watson 2002; Link & Phelan 2001). The analysis then considers community attitudes to mental health service users from the service users’ perspectives and develops this sub-theme further by looking at the implications for service providers, before widening the analysis again to the level of country (i.e. differences between Highland and Canada). Finally, the role of the media is considered in terms of its potential to contribute to stigma processes. Theme One comprises the Sub-Themes of: 1A) Everyday Stigma; 1B) Community Attitudes; 1C) Issues for Service Providers; 1D) Highland and Canadian Rural Culture; 1E) Othering and Identity Formation; 1F) The Contributory Role of the Media.

4.3.1 Sub-Theme 1A: Everyday Stigma

Given the characteristics of rural communities, where there are fewer people, with more intimate knowledge of each other, it seems that displaying behaviour which is considered
outside the accepted norm, or appearing ‘different’, has meant service users have often felt rejected and isolated within such communities because of their mental health problems:

‘Well I remember when I use to live in [...] some of the people [...] didn’t want to get close to me….didn’t want to get to know me [...] it was ‘oh no, we don’t want to associate with her’ (Female, Northern Alberta).

Indeed, whilst some participants had been open about their mental health status, they were often still confronted with overtly stigmatising attitudes:

‘I’m very open with it….. If I’m just meeting somebody for the first time, I’ll just say, ‘I’ll let you know right off, I’m bi-polar’ and some people have rejected me because of it’ (Female, Northern Alberta).

For some service users, reactions had been hostile, involving violent acts:

‘I knew two people that had to move because of their mental health problems […] The brick throwing and the litter was a constant feature’ (Male, Lower Highland).

Other extreme incidents included organised campaigns of ‘not-in-my-back-yard’ (NIMBY) where local community members had refused to share the same public facilities as the mental health population:

‘when I first came to this town, [mental health] was kind of a bad word [...] because there were a few places in town that Care Centre people would go for coffee [...] there was a couple of coffee shops that had to close down [also] they wanted to build a swimming pool [...] you should have heard the uproar [...] people were like, ‘no way, I’m not going there if the Care Centre people are using it’ (Male, Southern Alberta).

Additionally, receiving in-patient psychiatric care at the local asylum had led to hostile reactions from others in the community:

‘I know a lady, a very well turned out person…… with two really nice, clean kids and yet her husband, after she had been in Craig Dunain, was asked to keep her off the street’ (Male, Lower Highland).

However, in comparing instances of stigma in Highland and Canada, the data captures ways by which stigma was more problematic in Highland:
I use to have to take a boy home so that he wouldn’t get beaten up […] they use to chuck bricks and litter’ (Male, Lower Highland).

‘I know two other ladies who have the same [mental health] problems as I do, live in the same rough area and we all acknowledge to each other it is a problem for us’ (Male, Lower Highland).

‘I was abused because of it. I had the brick throwing thing through the windows’ (Female, Lower Highland).

In the above quotes, members of the public display the negative stereotypes they hold about mental illness (Corrigan & Watson 2002) by separating themselves from the stigmatised group (Link & Phelan 2001), sometimes through violent means. Moreover, such hostile reactions appear to be about the display of power over those perceived as having less power due to their undesirable characteristics (Link & Phelan 2001).

‘if you say, ‘oh I’ve got a mental issue’ they think you’re crazy you know, and they go like, ‘oh I’m gonna stay away from you’ (Female, Western Highland).

Again, stigma is evident in the need to stay separate from those labelled ‘crazy’, which essentially involves devaluing and rejecting them:

‘[various organisations throughout the Highlands] have been for years and years trying to break down stigma in mental health […] but stigma is [still] a terrible problem’ (Male, Northern Highland).

Much has been written on the issue of stigma, largely influenced by the work of Erving Goffman (1963). In his work *Stigma: Notes on the Management of Spoiled Identity* Goffman conceptualises stigma as ‘an attribute that is deeply discrediting’ and that reduces the bearer ‘from a whole and usual person to a tainted, discounted one’ (Goffman 1963, p. 13). From this perspective, the normative expectations that society has around conduct and character are used to judge the attributes that combine to make a person’s social identity. When a person is seen as ‘less than’, or where they are seen as possessing an attribute that makes them different, it creates a discrepancy between virtual and actual social identity; the undesired attribute that makes the person different, is a stigma. In this way, according to Goffman, the person who bears the stigma is discriminated against due to his perceived inferiority.
Of particular relevance to the current study is the notion of social information and visibility. In Goffman’s (1963) view, signs and symbols are used to convey information that is ‘reflexive and embodied’, or conveyed by the person it is about. In the context of mental illness, stigma symbols essentially draw attention to a debasing identity, one that encourages a reduced valuation by others thereby perpetuating a devalued identity for the bearer. In terms of rural communities, where people share knowledge of one another, such processes have serious and potentially lifelong implications. Whilst such signs are open to change in the normal course of life, in the context of rurality it can mean that such an identity remains ‘fixed’ and the person type-cast for as long as they remain within or attached to that particular community:

‘I find that when I go home to that island, there is such a stigmatism attached to the fact that I’ve experienced mental illness and still dealing with it’ (Male, Northern Alberta).

In this quote, despite moving away from the community in which he grew up, the participant’s identity (i.e. service user) had remained fixed, unaffected by time and space. As Nicholson (2008) notes, ‘Once a person has become socially excluded from society, it may become increasingly difficult to re-join it again, and the person may become trapped indefinitely on the margins of society’ (p. 308). Even if the stigma is not immediately visible to others, the social proximity that is characteristic of rural living can mean the community have knowledge of the person and their disability despite any attempts they may make at concealment.

A consequence of mental health stigma in rural areas is that it can contribute to a culture of secrecy and silence around mental illness (Niamh Louise Foundation 2012) and can lead to families trying to protect their relatives by hiding their illness (Nicholson 2008). However, data from the current study highlights the way in which families can also be a source of stigma for service users. Negative reactions to mental health problems are not simply reproduced and perpetuated by the wider community:

‘I’ve had it even when I lived in […], family members, they were fine until I got ill again […] then they didn’t want to know me…I wasn’t asked to babysit their kids or anything like that, and that’s family!’ (Female, Northern Highland).

‘my family, they don’t understand anyone with mental health problems’ (Male, Southern Alberta).
In this way, the re-emergence of mental health problems disrupted the relationship family members had with the participant, which in turn led to prejudiced thinking evident by discrimination (the behavioural reaction to prejudice) in the form of social distancing (Corrigan & Watson 2002). For some, experiencing stigmatising attitudes from family members was due to fear of reactions from the wider community:

‘The biggest stigma I’ve had recently would have been from family, feeling very frightened about the reaction of the local community’ (Male, Lower Highland).

It was also evident that some participants had self-stigmatised, ‘it took me years to come to terms with [the mental health title]’ (Male, West Highland). Internalising negative messages about mental illness meant that some were embarrassed to access services and were reluctant to let others see them doing so, despite the potential benefits of service support (Larson & Corrigan 2010). Other participants spoke of a prolonged period of ‘coming to terms’ with a mental health diagnosis. For some, however, historical attitudes to mental illness served as a cautionary influence in terms of disclosure:

‘culturally and historically our memory of stigma is maybe more powerful internally than what we actually experience in the community nowadays. There is so much memory of the horrors of everything and so much memory of how horrible people were – but in my day to day life, when people find out I have a mental health problem […] I usually get a very positive response [but] I still feel worried about revealing that I have schizophrenia to strangers because I have that perception that there may be a very negative reaction, even though most times there isn’t’ (Male, Lower Highland).

Internalising messages around mental health problems can thus create an overestimation around the expectation of facing discrimination (Stier & Hinshaw 2007).

4.3.2 Sub-Theme 1B: Community Attitudes to ‘Difference’

A central component in discourse about rurality involves the many ways in which people are connected to each other (Nicholson 2008). This can be through organized spaces, such as institutions and local groups, or more informal networks, such as family and neighbours. Given the dynamic of rural places, where people are socially proximate, it is often the case that such closeness and familiarity can produce shared knowledge about all those who reside in that space (Parr et al., 2004). This can be a source of inclusion, where being known and connected with others can give a sense of belonging and identity. It can also bring economic benefits in the form of employment or appropriation of local
resources. In the context of mental health, pervasive informal networks can mean service users become the subject of gossip within their communities; the fear of which can lead to regulating behaviour so as not to transgress localised social norms. For some participants in the study, the social proximity of rural living was conceptualised as almost claustrophobic in nature, where it was felt that their private lives unfolded publicly under the gaze of the local community:

‘Like coming from the village, I couldn’t wait to get out of the village….someone mentioned cliquishness, I felt it terrible in that place…everybody knew everybody’s business and I thought, ‘I’ve got to get out of this place’ […..] I think living in cliquish communities like that can affect people’s mental health!’ (Male, Northern Highland).

The impact of informal gossip networks was also highlighted as one participant described having to be hospitalised during an acute phase of his illness and realising that a local tradesman knew before his own family:

‘the second but last time I was in hospital, the local plumber knew I was in hospital before my family did, which I think is really important when you talk about rural stigma and knowledge’ (Male, Lower Highland).

Findings from the current study suggest wider community attitudes form a major part of the experience of rural mental health problems. Whilst this was evident in Canadian responses, it was particularly discernible within Highland data. Specifically, when asked if the community were accepting of people with mental health problems, all Canadian participants felt this was the case, in contrast to Highland participants who disagreed. Many Highland participants felt that the fear and ignorance that influenced perceptions of mental illness had not been broken down despite significant changes within mental health policy. Examples of apprehension around community attitudes included the fear that others would find out they have a mental health problem, ‘straining trying to pretend I’m normal’ (Male, Lower Highland). The prevalence of gossip networks, the idea that nothing escaped the prying eyes of the community, was felt to be a constant feature of rural living:

‘I’ve only been up here two years, if you’re going to the shops they seem to look at you, and you’re going ‘well what are you looking at’ and they seem to know you’ (Female, Western Highland).
Or, as one participant captured it: ‘you can’t go for a pee without them knowing’ (Male, Western Highland).

This illustrates the oppressive nature of such exclusion. The lack of privacy that is woven into rural life meant that negative attitudes to mental health could be used as a way to reinforce boundaries around what was considered acceptable:

‘he was actually asked to keep her off the street’ (Male, Lower Highland).

By being asked to ‘keep her off the street’, the stigmatised woman is labelled and set apart, essentially reconfirming her undesirable status and powerfully reinforcing the rationale for her rejection and exclusion (Link & Phelan 2001). Moreover, these attitudes to mental health were found to be entrenched in the Highlands, with some participants feeling that little had changed in terms of understanding mental illness, despite concerted efforts to raise awareness and tackle stigma:

‘somebody [was] coming here and the taxi driver turned around to them and said, ‘what’re you going in there for, that’s for the mental people’ […] if that’s the local image of what this place is, we’re never going to get anywhere’ (Female, Northern Highland).

For participants that had migrated into rural areas from urban ones, this lack of privacy was something that was surprising and disconcerting. Of note was the extent to which local people would strive to obtain information about the ‘newcomer’:

‘it’s something I wasn’t use to, being brought up in a city, so that’s taken a while to get use to that, the fact that people know who I am without me knowing who they are […] most of them knew exactly who I was and who my family was, so they knew the family connections, and that took a lot of getting use to’ (Male, West Highland).

Or how quickly familiarity could be established by local residents:

‘It takes a while for somebody from outside, coming here, to adjust to a smaller way of life […] Little things […] take a while to get use to…you’d walk into a pub and the guy would know you from the day before so he’d say, ‘the usual’ whether you wanted it or not and just put it down in front of you’ (Male, Northern Highland).

Whilst the tight-knit nature of rural communities may seem part and parcel of rural living, in the context of mental health, such visibility can have significant implications for service utilization and offers an understanding of why available statistics may not
represent the true scale of the problem in rural communities (Nicholson 2008). The pressure of conforming to a certain rural social identity, particularly around help-seeking, combined with a cultural norm of stigma about mental illness, can discourage any type of disclosure or engagement with services for those who could potentially benefit from an intervention (Larson & 2010). It can also mean that help is not sought until symptoms are more severe (Relf 2012). Indeed, the vast majority of Highland participants felt there were many more people in the community who needed help but who remained off the radar of mental health services. One participant noted the challenge of visibility as he described the difficulties faced by rural dwellers in terms of accessing mental health support:

‘I’m on the Board of the NSF [National Schizophrenia Fellowship] and we have a drop-in centre in a rural place in the Highlands and in that village nobody is a member. The reason being, the only property we could get was right in the middle of the main street and so all the members come from the nearest other local Highland village. By walking in the door, everybody sees.’ (Male, Lower Highland).

In this way, social visibility combined with gossip networks can place considerable pressure on service users to avoid engaging with mental health services, or to do so in secret in order to avoid knowledge of their mental health status being shared in the wider public domain.

4.3.3 Sub-Theme 1C: Issues of Visibility and Stigma for Service Providers

Visibility can also be an issue for rural mental health professionals. Service providers noted the way in which mental health professionals were held in high regard in rural communities. This meant they had to strive to maintain a particular image, even when not working, making it difficult to maintain a clear separation between their personal and professional life (Alan et al., 2008). Various solutions, such as living outside the community, had been deployed by some as a way of dealing with the overlap between the public and the private domain:

'I've chosen to stay out of the town, I live in a small village, but I always find it quite uncomfortable [...], bumping into people that you see.....but there is something about the fact that you have less privacy...because people know each other in rural areas' (Community Psychiatric Nurse, Highland).

'I don't live here [in the community] but I've worked here long enough....so there's
nowhere I can go that I won't run into clients' (Counsellor, Alberta).

However, chance meetings within the community were seen as problematic when these involved questions around clients and resources, again making it difficult to maintain clear boundaries and separate roles (Brems et al., 2006):

‘[people will approach you when you're out in the community] and say, 'oh, you go and see so and so don’t you'. It doesn’t bother me now. I just say, 'I'm sorry, I just can't discuss that with you' but you do get that much more because you're known in the community' (Occupational Therapist, Highland).

As previously highlighted, stigma is still a considerable problem for rural service users (most notably within Highland). For service providers, the issue of stigma is also problematic in terms of being able to reach people who need help. In Highland it was noted that when services have been available (in the form of groups), they have often failed due to service user apprehension that they may know others in the group. High levels of stigma coupled with the close-knit nature of rural communities meant that any level of service intervention was challenging due to service users’ fear of being labelled ‘crazy’ by the community:

‘[in the last place I worked] people came there who were acutely suicidal but they didn’t want to go to the [local] mental health clinic where somebody [from the community] might think they were crazy’ (Counsellor, Alberta).

In the quote above, despite experiencing an extremely negative mental state (i.e. being suicidal), the service user still opted to travel further to access emergency help for fear of others finding out.

'Self-stigma and of course the stigma from the community [is a huge problem]. The thing about a small town is everybody knows when you're having a problem’ (Intake Co-ordinator, Alberta).

'we've tried to persuade someone that it would be a really good if they had a support worker but they've said no because the rest of the community know that that person is a support worker.....that's a shame because it's preventing them from moving forward...all because of fear of rural gossip' (CPN, Highland).

The challenge of delivering mental health services requires careful consideration in terms of the rural dynamic: once a person is known within a community as a mental health
worker, it immediately casts suspicion on anyone else seen with that person. Hence providers attempt to discreetly provide services by, for example, matching provider and user in age and gender (to disguise the professional nature of the relationship), or by avoiding the use of anything that would signify their occupation:

‘... no uniforms because if you go into somebody’s house then it’s very obvious….It is about anonymity, people want to have their privacy and their anonymity safeguarded’ (CPN, Highland).

‘I wouldn’t even say I work for the social work department, I would say I work for the Highland Council…and obviously we don’t wear uniforms, we’ve got nothing that marks out who we are, including our cars [however] whilst you can reduce the immediate impacts with those things, once you get known as to who you are, you can never change that’ (MHO, Highland).

‘[a] psychologist down the hall from me….we talked about sharing office space, but she wants no signage, she wants an entrance in the back alley, so that people coming have privacy in the community…so people driving by can’t say, ‘oh look, there’s so and so going to the psychologist’ (Psychologist, Alberta).

The use of technology was also found to be an important way of providing people with the opportunity to access mental health services discreetly:

‘lots of people email me first because it’s safer’ (Psychologist, Alberta)

However, in line with the focus group data, responses from service providers reveal that stigma is considered less of a problem in Canada:

‘I think….probably stigma isn’t as bad now […] it’s probably improved but I still think that mental health…it’s a case of ‘mental health?’….it still has its challenges for people’ (Counsellor, Alberta).

‘I think [stigma is] much less an issue than it used to be. Back in the 1970s you just never even heard about it….even your Community Mental Health Centres, they were just kind of tucked away, no signage […] but now, people like to say, ‘I have a therapist’…..they like that word ‘therapy’ […] it’s trendy’ (Psychologist, Alberta).
4.3.4 Sub-Theme 1D: Highland and Canadian Rural Culture

The implication from this study’s findings is that the experience of stigma is more pronounced in Highland than in Alberta. The following section, therefore, outlines distinguishing features of Highland and Canadian rural culture that may offer some understanding of such differences.

As previously outlined, the Highlands and Islands is a unique geographic area of Britain not only due to the remote and dispersed nature of the communities but also due to the continuing influence of historical and cultural factors. Ties between inhabitants of rural Highland communities can extend over generations, with historic tales (and particularly injustices) embedded in the local collective memory that continue to exert an influence in the modern day:

‘There are few villages in the Highlands where similar memories are not still lurking in the recesses of the mind, quiescent for the most part, but sensitive as a hair trigger, so that crofters react instinctively to a contemporary situation, alert and wary, looking for some hidden threat to their hard-won independence’ (Grant 1977, p. 22).

There is also a sense of a strict moral ordering; historical tales show the way in which local community members have taken matters into their own hands in response to perceived wrongdoing (Grant 1977; Mathieson 2000). At this juncture it is worth mentioning the role of religion as a key aspect of Highland culture with particular implications for entrenched beliefs. In areas of the Highlands, such as the Western Isles, religious belief is strongly influenced by the doctrine of Calvinism and the notion of ‘predestination’. The importance of this for social and cultural life is significant. Strict religious practices that are averse to cultural expressions (such as dancing, speaking Gaelic, reciting poetry) combined with a general suspicion towards anything not directly linked to the church, have led to a heavy moralistic tone that pervades every aspect of social life there\textsuperscript{14}. As MacRitchie (1994) notes, ‘With the church’s strict code of expected behaviour, and constant alerting of the people to the dangers of this or that sin, people live with a heightened sense of guilt at what they have thought, said, done, or

\textsuperscript{14} In some parts of the Western Isles strict observance of the Sabbath means no work is to be done and recreational activities such as leisurely walking or even hanging clothes up to dry outside are frowned upon
failed to do’ (p. 275). Promoting the idea that some are beyond redemption due to predestination, or that guilt should form the backdrop of social existence, has significant implications in terms of mental health. It implies that those with mental health problems are somehow to blame for their symptoms, essentially encouraging repression for fear of retribution. For those who are unconnected to the church (‘the reprobate’), the impact of the message is even starker: it can leave them ‘with a deep sense, not only of unforgiven, but of unforgivable sin’ (MacRitchie 1994, p. 275).

Such cultural factors are important because they represent a way of life through shared values and beliefs about what is morally right or wrong; reflecting ideals and visions of what society should be. Such values shape behaviour and ideas by providing the guidelines for how people should conduct themselves (Brennan 2005). Indeed, such a repressive culture is arguably linked with excessive levels of alcohol consumption in Highland (Anderson & Plant 1996), which has become so widely accepted it has become a cultural norm (Dean 2002). As one service provider noted, abusing alcohol is seen as socially acceptable in the Highlands and allows the individual to ‘fit in’ in a way that would potentially not be possible if the person were to disclose that they had a mental health problem:

‘people will sometimes mask mental ill health with alcohol misuse and that is quite commonplace, so you could almost ‘fit in’ by being someone who misuses alcohol….it’s not even considered misuse or problematic…and it’s acceptable, it’s completely acceptable’ (MHO, Highland).

There can even be expectations, and consequent pressure, around alcohol consumption, the refusal of which can lead accusations that something is wrong with the person:

‘A friend of mine comes up every so often […] and sometimes I drink [with him] sometimes I don’t drink [but] he [always] expects me to be in the [bar] with him drinking […]. I have to try and justify myself to him. He’ll phone me up and say, […] Are you coming in for one’, ‘you know I’m not drinking […] I’ll be going to [the drop-in]’. He’ll then say, ‘what is it with that place, why have you got to go in there every day’. I try and explain to him that I don’t have to go in every day, it’s my choice’ (Male, Northern Highland).

In this way, cultural norms that are influenced by strict moral codes can combine to create a collective disposition that is suspicious or even condemnatory of mental illness. Within this climate, alcohol can therefore serve a dual purpose: it can allow the person to
‘fit in’ with the local community and it can mask underlying mental health problems either through repression or by permitting the expression of odd behaviour that can be attributable to inebriation (Burns et al. 2002b, p. 12).

**Canadian Culture**

As previously noted, the Canadian communities in the study are of much more recent origin than the ones in Highland. Historically, the period before the three communities were created was a time of significant in-migration to Canada. In this context, there was enormous pressure on available agricultural land suitable for the influx of settlers, leading many to move to less desirable and more remote land. This rural-overpopulation created transience and poverty for migrants and, coupled with extreme harsh winter conditions, placed a premium on mutual support and cooperation in order to survive (Bumsted 1998). Essentially, geographic isolation coupled with inclement weather conditions demanded that frontier and rural people developed informal support networks as a way to overcome the challenges of daily life (Cates et al., 2012).

A diverse immigrant population, coupled with a prevailing sense of community is something that has arguably continued through to the modern day in Canada. In particular, the government places importance on social cohesion, national identity and shared values (Bannerman 2011). In this way, cultural values that emphasise diversity and tolerance, and that are underpinned by the notion of social cohesion offer some understanding as to why community attitudes to mental health service users differ between the two countries.

In terms of the role of religion, this seems to stand in stark contrast to its influence in Highland. As previously noted in Chapter Two (p. 64) the role of the church has been portrayed by some academics (see Voss 1996) as a positive agent in relation to rural mental health, with a key role in terms of bringing diverse groups together and facilitating information diffusion that can potentially help those who require mental health support and care. Such a portrayal seems a world away from the heavy moralistic and repressive atmosphere noted in some parts of Highland. Thus, Canadian society promotes the idea that despite differences between people, shared values and a common identity are the fundamental principles that underlie and unite all such diversity. (However, the search for consensus on Canadian national identity is worthy of note, Nimijean 2005).

Nevertheless, the idea that stigma is more prevalent, or that it represents more of a problem in Highland than it does in Canada, is not consistent with the wider literature.
As previously noted on there is still considerable underutilization of available mental health services (Jagdeo et al., 2009; Tempier et al., 2010), with studies showing that some Canadians would be unwilling to accept the mentally ill as friends, or in a professional capacity as a family doctor (Canadian Medical Association 2008). In terms of professionals, in some rural areas of Canada family doctors are increasingly screening out individuals with mental illness who have complex health needs (Canadian Mental Health Association 2009). Indeed the lack of parity of treatment/attitude with other illnesses by doctors, or the notion that mental illness is not accorded the same value as physical illness, has meant mental health stigma has become a ‘national embarrassment’ (Canadian Medical Association 2008). In their study on rural and northern women, Liepert and Reutter (2005) found that rural norms and values (associated with historical ‘frontier’ attitudes such as hardiness) were found to perpetuate stigma and inhibit women from help seeking. (Indeed, the theme of survival was historically a key definer of Canadian identity; specifically centred around the belief that only strong people could survive such a difficult climate unlike their southern neighbours in the United States, Nimijean 2005). More recently, the Canadian Psychiatric Association released a position paper on stigma and discrimination faced by people with mental illness, calling for Canadian psychiatrists to ‘take a leading role in addressing these crucial issues’ (Abbey et al., 2011, p. 1). In particular, they note the extent to which discrimination is directed towards mental health at all levels (to patients, mental health care providers and psychiatry as a profession).

The wealth of anti-stigma initiatives in Canada is reflective of the level of concern about the impact of stigma on the lives of people with mental health problems: Opening Minds (Mental Health Commission of Canada 2013); Partners for Mental Health (http://www.partnersformh.ca/); Elephant in the Room (http://www.mooddisorderscanada.ca/page/elephant-in-the-room-campaign). However, in terms of tackling stigma there is an admission that ‘Canada is far behind other nations in this regard’ (Goldbloom & Bradley 2012), with some suggesting that the Canadian public are now more inclined to perceive people with mental illness as dangerous, despite

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15 As noted by the Canadian literature review, most mental health research draws from a quantitative paradigm, the findings from the current study suggest that further qualitative work needs to be done to explore the issue of stigma and community acceptance for rural service users.

16 For a full list of anti-stigma initiatives in each province, please see Mental Health Commission of Canada: http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Key_Documents/en/2008/AppendixxC.pdf
decades of anti-stigma initiatives (Bourget & Chenier 2007). In relation to the policy of multiculturalism, this suggests cultural values such as respect and tolerance of difference may only extend along racial and ethnic lines.

4.3.5 Sub-Theme 1E: Othering and Identity Formation

The above discussion on stigma highlights the serious and potentially debilitating implications of being labelled ‘crazy’. The literature highlights a key feature of stigma as relating to the process of ‘othering’; of separating ‘them’ from ‘us’ (Link & Phelan 2001). The concept of Othering has also been found in subjects as disparate as Orientalism (the Western mis-construction/oversimplification of Arab and Muslim identity) (Said 1978) and reality television (Lawler 2005). Fundamental to this is that identity is constructed in relation to differences rather than similarities with other: ingroup identification is linked to perceptions of similarity, proximity and familiarity (Hinshaw 2007, p. 29). According to cultural theorist Stuart Hall (1996), identification is a process that works across difference involving the ‘binding and marking of symbolic boundaries’. Identities function only because of their capacity to exclude, to leave out. As he notes, ‘Identities emerge within the play of specific modalities of power, and thus are more the product of the marking of difference and exclusion’ (Hall 1996, p. 4). In this relational grouping of identity, one group tends to carry a vaguely positive ‘unmarked’ identity, whilst the other carries a negative ‘marked’ identity (service user). Indeed, responses around this suggest it is part of the lived experience of rural service users, to be related to by the community in terms of their collective ‘marked’ identity of mental health service user. In the context of stigma, being grouped or associated with a devalued identity serves to reaffirm the status of service users as ‘different’, essentially contributing to their social exclusion.

The production and reproduction of difference in this way serves to demarcate boundaries between ‘them’ and ‘us’. Whilst this relates to thinking about difference (mad versus normal), it can also create spatial divisions, for example through the exclusion of the sick from the healthy by hospitalization (Wilton 1998). Indeed, organised ‘nimby’ campaigns reflect this threat of geographic proximity to difference, with some campaigns ordering high fences to separate the community from the supported housing projects (Sayce 2000), serving as a literal as well as symbolic demarcation of difference. Indeed, in Canada, the perceived threat to the social order (from ‘them’) resulted in forceful acts in the form of boycotting community facilities, as a way to maintain boundaries:
‘there was a couple of coffee shops that had to close down’ (Male, Southern Alberta).

In this example, the suggestion that the normal population would have to share local facilities with ‘them’ provoked intense revulsion (Dear 1992), leading to practices that reinforced and reproduced positions of dominance and subordination (Johnson et al., 2004); essentially maintaining the social order.

A further dimension to this suggests that the mentally ill person serves as a reminder of the fragility of life and of the human psyche. Goffman himself confirms such ideas: ‘The stigmatized and the normal are part of each other; if one can prove vulnerable, it must be expected that the other can, too’ (Goffman, 1963, p. 161). In Foucault’s *Madness and Civilization* (1989) the fear and anxiety directed to unreason, or madness, is captured from an historical perspective. For Foucault, the fear of confinement that spread throughout Paris during the eighteenth century created an air of repulsion, fuelled by moral myth and unreason, around the evil of confinement; it was conceived of as something that was contagious and to be avoided for fear of infection (1989, p. 192). Whilst it is arguable that western society has progressed considerably in the intervening years, the notion that judgements are formed somewhere between medical fact and moral myth, may still have some bearing in terms of Highland (see above discussion on the role of religion in Highland).

4.3.6 Sub-Theme 1F: The Contributory Role of the Media to Mental Health Stigma

In recent years, sensationalist media portrayals of mental illness have captured the public imagination by emphasising the unpredictable, dangerous and sometimes fatal consequences of mental illness (McKeown & Clancy 1995; Cutcliffe & Hannigan 2001; Anderson 2003; Whitley & Berry 2013) and by making clear links with criminality (Ward 1997). Such associations with have meant it can be more reassuring to learn that someone was shot to death during a robbery than stabbed to death by a psychotic man (Marzuk 1996). Despite the prominent role of news media as a source of mental health information, representations of mental illness continue to be negative. In general, they tend to emphasise the violent and delusional behaviour of people with mental health problems as a way to attract attention, which in turn reinforces stereotypical thinking (Cross 2004).

For the majority of participants, the media was perceived as the single most contributory
factor when it came to reinforcing prejudiced beliefs. In particular, mental illness was often associated with violence, with very little accuracy portrayed in the media in terms of the lived reality of mental illness:

‘every time you turn the telly on in the evening, there will be a detective story about some psycho who has killed someone and it will be a satanic ritual. It’s so distorted from the reality of mental illness but the general public, and we, internalise the message that people with mental illness are violent and dangerous. Maybe the responsible media doesn’t say it but those television programmes always reinforce that negative attitude towards people with a mental illness and build up a completely false stereotype’ (Male, Lower Highland).

The idea that people with mental health problems can be portrayed as doing the normal round of things in life was considered not entertaining enough for the public:

‘it’s more entertaining than having someone just chatting away, or getting their medication or whatever…not necessarily climbing the walls or throwing things’ (Female, Northern Highland).

The heightened awareness of the potential risks associated with community care is arguably linked to the large numbers of people receiving psychiatric care in the community (deinstitutionalisation), meaning the boundaries between the ‘mad’ and non-mad’ are no longer obvious (Lalani & London 2006). Headlines such as ‘Mentally Ill Freed To Kill’ and ‘Two Women Stabbed in Street by Maniac’ (Kerry 2012) not only portray mental illness in a way that sells but also serves to increase anxiety on the adequacy of community care. As Warner notes, ‘Homicides by people with mental health problems are presented in the media as an outcome of the failure of community care policies to contain ‘dangerous people….and of individual professional incompetence’ (2006, p. 226). In this way, the relationship between the media and mental illness is one of exaggeration and fear mongering which encourages blame (Lalani & London 2006; Warner 2006).

Whilst such portrayals can influence and perpetuate stigma and discrimination in wider society, for service users the effects can be overwhelmingly negative. For instance, negative media depictions can impair self-esteem, help-seeking behaviours, medication adherence and overall recovery (Stuart 2006):
‘there’s so much [inaccurate] stuff in the media….We grow up with it as part of our everyday experience, these sort of negative images’ (Male, Lower Highland).

As noted by Beresford (1998)

‘The most appalling Victorian stereotypes of sub-humannity, dangerousness and axe-wielding murder have been reinforced with all the power and subtlety of the modern media. It is probably difficult to overestimate the destructive effects that this has, both for current mental health service users and for anyone facing madness or mental distress for the first time’.

In the context of social exclusion, negative and exaggerated media portrayals can impact on how friends and families treat service users and, in some instances, can discourage service users in terms of job seeking or volunteering work (Baker & MacPherson 2000, cited by Stuart 2006).

Nevertheless, in Canada, the Mental Health Commission has sought to break down stigma through contact-based education. This approach involves targeting specific groups (i.e. healthcare providers, youth and media professionals) and allowing them to hear from those who have experienced mental health problems and have successfully coped (see Opening Minds http://www.mentalhealthcommission.ca/English/Pages/OpeningMinds.aspx). In the context of media, the Opening Minds campaign has included presentations to journalism students in various universities across Canada, allowing them to hear from, amongst others, established journalists with mental health problems in order to understand what it means to experience mental health stigma in everyday life. By targeting journalism students in this way, the program aims to raise awareness around the importance of responsible reporting in relation to mental health. Indeed, evaluations of the program to date have shown that it can reduce stigma and promote positive attitudes towards those with mental health problems (Lillie et al., 2013). Such steps can be seen as important given the potential of the media to influence opinions on mental health:

‘people are scared of people with mental illnesses because all they see is negativity. Everything is sensationalised on television……you have someone who is schizophrenic and they’ve gone in and slaughtered some family […] or if someone is bipo…ar, they’ve gone in and hurt somebody or taken someone hostage […] all people hear is this negative crap’ (Female, Northern Alberta).
4.4 Theme 2: Complexity of Place

The second central theme to emerge from the analysis is in relation to the complex ways service users conceive rural spaces. Evidence from Theme One shows that rural communities can be experienced as unforgiving places by those who display behaviour that is ‘different’. For some participants (most notably in Highland) this was a key factor in terms of migrating out of the area. For Canadian participants the decision to relocate was often resource-based. Whilst the subject of migration has been written about extensively, less is known about the motivations for migrating for those with existing mental health problems (Philo & Parr 2004). Therefore, as a starting point to this theme, the sub-theme of migration is explored. The findings in this section therefore offer an important contribution to existing knowledge.

The data reveal that the impact of being ‘different’ in a rural environment is complex for service users. Specifically, despite experiencing social rejection many participants still regarded rural spaces as safe; as evoking a sense of belonging and connection akin to the rural idyll. Theoretical explanations for this are drawn from ‘place-identity’ theory (Proshansky 1978), highlighting the impact of place in terms of cognitive dispositions and identity formation. Such findings are particularly important in terms of understanding how rural dwellers construct the rural (Halfacree 1995). Thus, Theme Two broadly concerns participants’ relationship to rural spaces. It offers a more nuanced understanding of rural places than Theme One by demonstrating the way they can be conceived as both a source of exclusion and inclusion and thus the experience of mental health problems within a rural community spans these feelings of being both ‘in’ and ‘out’ of place. Theme Two is made up of three Sub-Themes: 2A) Migration; 2B) Rural Affinity; and 2C) Idealised Notions of Rural.

4.4.1 Sub-Theme 2A: Migration Amongst the Mental Health Community

The process of othering and of distancing by the community offers an understanding as to why some participants had chosen to migrate to other areas. Some focus group participants expressed the idea that moving would somehow allow them to escape from the ‘prying eyes’ of the community, or would afford them the opportunity to connect with others in a way that had not been possible in their previous location. For a number of participants, particularly in Alberta, the decision to relocate was due to availability of services:
‘…this was the motivational factor to move here for me, as a disabled Canadian….because the services were here that were not elsewhere……’ (Male, Northern Alberta).

‘a lot of the patients that come to the Care Centre come from out of town… and when they’re discharged, a fairly significant amount of people, for whatever reason, stay in this community rather than going back to their home town……so for a community of this size, it probably has a much larger population of people with psychiatric issues than your average rural community’ (Female, Northern Alberta).

‘when I was having my problems of old back home, if we’d have had something like this for when you were having problems […] I would never have had to come here……’ (Male, Southern Alberta).

Whilst not all participants articulated their reasons for moving, some did speak of difficult personal circumstances that had forced them to leave; moving, therefore, offered them the chance of a better life (Philo & Parr 2004):

‘I moved up from […] my wife died, left me with two girls…and life down there was getting rough, worse […] It takes a while for somebody from outside, coming here, to adjust to a smaller way of life […] You’d go into the Post Office and Mary would be telling the woman behind the counter, she put her washing out the other day …all you want to do is go in and get your money, then get your groceries! Little things like that take a while to get used to’ (Male, Northern Highland).

‘When the opportunity came to move, I went for it. I’d just reached a point where I was eroded away…rotting […] sitting indoors waiting to die’ (Female, Lower Highland).

Much has been written on the subject of migration in terms of the traditional rural-urban dichotomy. However, in recent years increasing attention has been paid to the counter urbanisation phenomenon, centred around the idea that migration to rural areas is a form of ‘anti-urban reaction and the search for a perceived superior quality of life associated with rurality’ (Farrell et al., 2012, p. 35), essentially leading to constructions of an idealised notion of rural life akin to the rural idyll. In the context of mental health, the above quotes highlight the way in which moving to a rural area, from an urban settlement, was layered with such sentiments. In particular, the idea that the rural landscape would somehow offer them a refuge from the environments in which they
found themselves in. Such findings are particularly important, as Philo and Parr (2004) highlight, whilst there is limited literature on migration and mental health, less is known about the migration of people with mental health problems (incipient or diagnosed).

The idea of therapeutic landscapes is pertinent here, as it captures the way in which people seek healing in certain locations (Gesler 1992). As Williams notes, ‘therapeutic landscapes are those changing places, settings, situations, locales, and milieus that encompass both the physical and psychological environments associated with treatment or healing’ (1998, p. 1193), essentially bringing together health and place. Given the images of rural landscapes as wide open expanses, with rolling hills, ‘the fresh air and pure water of the countryside’ with its ‘magnificent scenery’ (Gesler 1992, p. 736), ‘a utopia of harmony, tranquillity and safety’ (Rofe 2012, p. 1) it is not difficult to understand why a person would seek to find healing in such a setting. As the above quote highlights, the participant was ‘waiting to die’ feeling ‘eroded away…rotting’; migrating to a rural area was then about healing and restoration, being able to find herself again after the catastrophic impact of the abuse she experienced. Nevertheless, seeking landscapes or environments in which to heal may present their own unique challenges. As one of the quotes above highlights, the participant had migrated to a rural area following the tragic loss of his wife. However, in discussing his migration to the Highlands, he describes his initial thoughts about the landscape as potentially isolating, something that may seem appealing for temporary visits but presents something quite different in terms of a permanent location to live:

‘We went up to […] I’d been there on holiday, but to go over and actually live there…if you want isolation, go to [that] island […] there’s nothing, you know, just nothing’ (Male, Northern Highland).

Describing the landscape in this way runs contrary to notions of a therapeutic (rural) landscape (Ulrich 1979) and indeed such natural environments can be a stressor in the context of mental health (Rainer & Martin 2012).

In terms of migrating to rural areas, the in-flow of urban dwellers to rural communities can create tension and conflict with the local population, captured by academics as the ‘local-incomer’ dualism (Halfacree 2001). The idea of being positioned as an outsider in relation to local can have significant implications in terms of social exclusion as it can impact on the possibility for incomers to move beyond their incomer status (Burnett 1998). In the context of mental health, such tension can be even more pronounced.
Trying to find tolerance or support from locals can be difficult if they are suspicious or hostile to both incomers and mental ill-health (Philo & Parr 2004). In line with this, one participant who had migrated from a large, urban settlement in England, captured this suspicion:

‘if you’re going to the shops [the locals] seem to look at you’ (Female, Western Highland).

Some responses, however, around the issue suggest it is not static; familiarity and time were found to be important in terms of reducing hostility or suspicion. For example, in describing his migration to the area from an urban settlement in Scotland, one participant noted:

‘when I came up at first […] they barely spoke to you in the street, but that’s changed, I know everybody now’ (Male, Western Highland).

For those who had moved to more populated areas, some had returned to rural areas despite the drawbacks that had caused them to move in the first place. One participant had initially talked about the cliquish behaviour of rural residents, and the way in which she had been ignored by her neighbours due to her mental health status. However, as she notes:

‘I’ve lived up here all my life apart from [living in a city for three years] and I’ve got to say, I prefer the quietness. Okay, after living there for three years, it took a bit of getting use to the buses being every hour instead of every ten minutes but I personally prefer the peace and quiet’ (Female, Northern Highland).

In this way, despite the greater variety of city living and the potential opportunities to forge new friendships, the rural environment engendered a sense of belonging and connection for her, demonstrating the importance of contextual effects in relation to rural mental health (Wainer & Chesters 2000). In the same vein, another Highland participant described the difficulty of growing up in a rural village because of the constant surveillance by the community:

‘coming from the village, I couldn’t wait to get out of the village….someone mentioned cliquishness, I felt it terrible in that place….everybody knew everybody’s business’ (Male, Northern Highland).

However, the participant had returned to live in the same rural community many years
later. Being able to reconcile the negative aspects of rural living with the positive was attributed partly to his involvement with mental health support groups. Such involvement had not only allowed him to accept his mental health status but to be empowered to speak up about it:

‘I think it’s because of the [mental health] work I’ve been involved with over the years that has broken down [my] barriers in terms of being involved with a place like [this organisation]. I’ve realised, you have to stand up and be counted regardless of what you are, who you are’ (Male, Northern Highland).

The idea of returning to rural areas after a prolonged absence is referred to in the literature as ‘rural return migration’, focused on those who have lived in rural places, migrated out and then chosen to return to them (Reichert et al., 2011). As previously highlighted, one Highland participant in the study had migrated away from the area due to embedded local gossip networks and yet returned to the same community, positioning him ‘somewhere between local and incomer’ (Laoire 2007). The consequences of this can be particularly challenging in terms of not fully embodying either status, further compounded by a mental health status. Nevertheless, his involvement with a local mental health voluntary organisation had been an important factor that mediated between the varying positions. The difficulty with adjusting back to familiar areas was also captured for one participant (see above quote) in more functional terms (Halfacree 1995) when she talks about ‘getting use to the buses being every hour’ (Female, Northern Highland). However, describing the rural area she had migrated away from in this way also draws heavily from idealised notions of rural living, particularly noting the ‘peace and quiet’ (Laoire 2007).

4.4.2 Sub-Theme 2B: Rural Affinity

In a number of cases in both Canada and the Highlands, participants had migrated to other rural areas, perhaps having more of an affinity with such places despite the obvious drawbacks of accessibility and availability of services:

‘[rural communities] are nice, like you’ll say ‘hi’ to people and they’ll say ‘hi’ back….your bank teller knows who you are, your pharmacist, just different people like that’ (Male, Southern Alberta).

‘I love the rural communities [I’ve lived] in I would never go back to a city’ (Male, Western Highland).
Theoretical explanations around a rural affinity can be drawn from environmental psychology and place-identity theory. The theory focuses attention to the influence of the physical environment on identity and self-perception. According to this perspective, the people-environment relationship is dynamic and interactive (Franck 1984) and is based on ‘holistic and reciprocal interaction’, in other words both affect and influence each other (Hauge 2007). Earlier proponents such as Proshansky (1978) suggest that places and spaces, as an influence on identity formation, are important in that they provide the physical contexts for all of the social and cultural influences on the self. Understanding this backdrop upon which social life arises and finds its meaning is valuable, as Proshansky illustrates, a family is not simply about people, it is also a place called home.

The interplay between place and identity is defined as ‘the dimensions of self that define the individual’s personal identity in relation to the physical environment by means of a complex pattern of conscious and unconscious ideas, beliefs, preferences, feelings, values, goals, and behavioural tendencies and skills relevant to this environment’ (Proshansky 1978, p. 155). Indeed, the places where people live and become attached to may affect the type of environment they seek out (Hauge 2007). Of interest to the present study centres around the notion that the physical environment provides the context for the things people believe and expect to experience in their daily settings; it defines the ‘who’, ‘what’ and ‘where’ of the person, along with how they will behave. Whilst such aspects may not be consciously articulated by the individual, it can exert an influence in terms of feelings and preferences in relation to particular places or settings. As many participants noted, they would only ever live in rural areas, essentially reflecting this interplay between the inner and outer realm: ‘I’m a rural person, I like the rural area better than I do the city because......I don’t think the city is as compassionate as a rural area is’ (Male, Northern Alberta). Despite the drawbacks of living in rural areas, for example social visibility and isolation, many felt such places were safer and gave them a sense of belonging and identity:

‘you can go down the street and meet people, stop and talk [....] I think with the rural situation, you have a higher degree of acceptance and compassion.....because you get to know people quite well. Often your relationships in the city are very superficial. It can be lonely. In rural areas, you know somebody’s family and you’re able to reach out and help others’ (Female, Northern Alberta); findings also highlighted by Ekeland and Bergem (2006) and their study of rural service users in Norway.
Further, whilst the physical dimension influences identity on an individual level, there are also general place-identity characteristics which exert a collective influence on individuals and specific groups living in particular physical settings, for example rural versus urban (Proshansky 1978):

‘I like it here because, although everyone knows you, that’s a nice thing. If you’re isolated somewhere in a big city, where you’re just a pin in a haystack, a wee place like this is so different’ (Male, Northern Highland).

Nevertheless, whilst a number of participants had moved between rural areas in the study, some had migrated from urban areas to rural areas, suggesting the process is not static and is open to change.

4.4.3 Sub-Theme 2C: Idealised notions of rural

In line with Wainer and Chesters (2000), participants were able to articulate both positive and negative features of ‘their place’ (p. 143). As previous examples highlight, rural living can be claustrophobic, where private life becomes public life; essentially creating additional pressure for those who are experiencing mental health problems. It can also be challenging in terms of community attitudes to mental ill-health which can lead to distancing and ‘othering’. Despite this, however, many participants noted the way in which living in a rural community can promote a feeling of comfort due to knowing more people in the immediate environment:

‘I like it here because, although everyone knows you, that’s a nice thing’ (Male, Northern Highland).

‘I would never go back to cities now’ (Female, Western Highland).

‘I don’t think the city is as compassionate as a rural area is’ (Male, Northern Alberta).

‘I can walk down the street and talk to just about anybody because I know them...in the city you don’t have that as much, because your anonymous’ (Male, Northern Alberta).

The concept of the ‘rural idyll’, the notion that the countryside is safer, healthier and less-hurried has long been a part of popular and academic consciousness (Watkins & Jacoby 2007). In the above quotes there is the sense that participants subscribe to this
representation of the rural. In particular, participants situate rural areas in relation to how they felt or imagined the city to be; conceived as spaces that were essentially dangerous or unfeeling, the hostile ‘urban ghetto versus [the] rural haven’ (Wainer & Chesters 2000, p. 143), where the bonds of familiarity and connection were somehow absent. In this way, rurality was described in more abstract terms (Halfacree 1995), involving expressions such as ‘compassionate’, ‘higher degree of acceptance’, and ‘everyone knows you’. In capturing these subjectivities, it can be seen that such descriptions are arguably at odds with earlier quotes that convey rural communities as challenging and difficult to live in for those who are different. Such descriptions project a conflicting and contradictory image of rurality. Nevertheless, that participants describe the rural as a source of both inclusion and exclusion suggests that these framings ‘are not a naïve acceptance of the idyll but involve(d) a more engaged and often critical reflection on rural living’ (Halfacree 1995, p. 1). Such findings are particularly important in terms of understanding how rural dwellers construct the rural (Halfacree 1995).

For some, living in rural places was simply a personal preference due to being uncomfortable around large crowds of people; living in a less populated place therefore gave them a sense of control in terms of social contact:

‘I don’t like crowds. I mean I like people but I don’t like them touching me and I don’t like noise levels, so I’m fine here in a rural area’ (Female, Northern Alberta).

This safety/danger element (Halfacree 1995) was also discernible in Highland:

**Extract: 1 (West Highland)**

<table>
<thead>
<tr>
<th>Male 1:</th>
<th><em>I can leave my door open here</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female 1:</td>
<td><em>I do</em></td>
</tr>
<tr>
<td>Male 2:</td>
<td><em>I don’t. I’m still city minded about that, I’ve had too many break-ins to be like that</em></td>
</tr>
<tr>
<td>Male 1:</td>
<td><em>some nights it’s not even locked during the night</em></td>
</tr>
<tr>
<td>Female 1:</td>
<td><em>I’m the same</em></td>
</tr>
</tbody>
</table>

In the above extract, rural areas were articulated in terms of the feelings of safety that they evoked, noted by the way in which participants felt able to leave their door unlocked. In contrast, the city was associated with crime (Male 2) which created a
certain disposition around keeping safe (‘city minded’).

The level of comfort was clearly a reason why many participants chose to stay in rural spaces, despite some of the limitations. Indeed, despite experiencing varying forms of stigma and distancing by the community, there were potential benefits to being socially proximate. As one participant noted, getting to know others in the community, and being known in the community as someone with a mental health problem, was found to act as a safety net when they were experiencing an episode of mental distress, acting as a signal to let others know that they were unwell:

‘[being known as a service user] in a way that helps you, it’s a positive sign, because you are known… I’ve got a guy who delivers food to me and he’s my unofficial social worker, I see him twice a week, if he doesn’t see me, he knocks on the door…. if I’m not well he cuts up the wood or does other things for me around the house’ (Male, West Highland).

In this way, traditional collective social practices of helping out in the community (arguably linked to the demands of maintaining self-sufficiency in such isolated areas) were important. Such caring practices may not represent any lasting commitment to inclusionary practices (Parr et al., 2004), and may not be captured in any official capacity, but it does demonstrate the complexity of social inclusion and rural mental health.

Whilst the above discussion highlights the positive aspects associated with rural life, it does not detract from the poor level of mental health support in rural areas. In some instances, those living in rural areas of Highland that become acutely unwell have been held temporarily in police cells due to inadequate escort arrangements (Remote and Rural Areas Resource 2003). Overwhelmingly, there was a sense from service providers that took part in this study that there were significant gaps in service provision in rural areas of Highland and Alberta. The Occupational Therapist that was interviewed was singularly covering a large geographical area of the Highlands (categorised as ‘Mid Highland’), the stress of which had made her seriously ill. Moreover, in response to such limited rural service provision, it was noted that GPs were over referring people to Community Mental Health Teams, potentially as a ‘fail-safe’ policy:

‘The GP is the gateway to most health service [….] but the GPs themselves don’t have a difficulty at all referring people in […] because there isn’t anything else up here, because there is limited services, we get quite a lot of referrals that aren’t
appropriate and should have gone somewhere else’ (CPH, Highland).

In some instances it was noted that GPs would not travel from their area to the mental health facility, New Craigs Hospital, in order to facilitate the legal process associated with Guardianship Orders:

‘if someone is up in New Craigs, their doctor won’t travel there to provide a report…and therefore you can have problems getting a medical report for someone’ (MHO, Highland).

In Alberta, some rural areas had been left without a psychiatrist for considerable periods of time: ‘we were without psychiatry […] for almost a year’ (Intake Coordinator, Alberta).

For professionals in this study, it was generally felt that rural areas were often forgotten about or were given limited resources, with service provision geared towards large populations. Indeed, findings from the Mental Welfare Commission Scotland (2012) highlighted a number of variations in the use of emergency detention certificates (EDCs)\(^\text{17}\), short-term detention certificates (STDCs)\(^\text{18}\) and compulsory treatment orders (CTOs)\(^\text{19}\), with considerably high numbers for NHS Highland compared to other Health Boards. In terms of EDCs, the findings show that Highland was ranked fifth highest of all Scottish Health Boards at 129. For STDCs and CTOs, Highland ranked sixth highest at 196 and 82 respectively, and after Greater Glasgow and Clyde, Highland has the highest rates of new CTOs (63). According to the Commission this variation in rates ‘may reflect the challenges in providing community services to a scattered population’ (p. 34). The rise in the use of the Mental Health Act (i.e. through Emergency Detentions, STDCs and CTOs) has been a consistent trend over the last four years in Highland, leading to concerns by the Commission ‘that areas with high use may be intervening excessively where there may be alternatives to depriving people of their liberty’ (p. 30).

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17 EDCs should only be used if it is not possible to secure assessments by both an approved medical practitioner and a mental health officer. It is likely to be used in crisis situations.

18 STDCs should be the usual start for an episode of compulsory treatment. An STDC involves examination by an approved medical practitioner (AMP) and consent from a mental health officer (MHO).

19 Compulsory treatment orders are granted by the Mental Health Tribunal. They last for six months, can be extended by the responsible medical officer for a further six months and then extended annually. The Tribunal reviews them at least every two years. Therefore, they can restrict or deprive individuals of their liberty for long periods of time.
Moreover, there remain challenges in recruiting sufficient psychiatrists to visit Highland.

4.5 Theme 3: Service User Narratives: The Challenge for Social Inclusion Policy

The final theme in this chapter centres on the relationship between the policy of social inclusion and the lived reality of being a service user in a rural place. Capturing service user narratives as part of the analysis was important in order to assess whether policy is aligned to the needs of those who use mental health services. Theme Three is important because it shows that, far from feeling powerless and vulnerable, participants were empowered and felt able to challenge stigmatising attitudes in their communities. Evidence from the ‘mad pride’ (Lewis 2013) movement (discussed further in this chapter) demonstrates a reclaiming of madness in contemporary western societies in ways that reconstruct ‘the problem’ of mental illness; essentially challenging the homogenous vision of social inclusion. However, the data reveal the way in which service users have often been rejected from the mainstream society in which they are encouraged to be part of, again challenging the implicit assumptions contained within the policy of social inclusion; the idea of a benign effort on behalf of exclusionary agents to ‘include’ (Spandler 2007). Finally, social inclusion policy uses employment as a key signifier in relation to inclusion but participant narratives challenge this by offering a reconceptualization of value in relation to being productive. In particular, employment forms only one aspect of what participants view as important in their lives. Theme Three therefore demonstrates an overall ‘rhetoric-reality gap’ (Nimijean 2005). The following discussion of Theme Three ‘Service User Narratives: The Challenge for Social Inclusion Policy’ therefore looks at the Sub-Themes of: 3A) Empowered Voices; 3B) Excluders as a Source of Inclusion?; and 3C) Reconceptualising Value.

4.5.1 Sub-Theme 3A: Empowered Voices

In capturing what it means to experience a mental health problem in a rural area, it seems that participants use a number of narratives around mental health. One narrative in particular is layered with concepts such as empowerment and motivation, and in many ways suggests an ‘active’ language. This was conveyed by the ways in which service users spoke of their experiences around consultancy and mental health training, in a bid to raise awareness of mental health issues. It was also evident by the reaction of
members to the potential closure of one organisation in the study. On a personal level, a number of service users evidenced an active language in their interactions with people in mainstream society, most notably the way they felt empowered to disclose that they were using mental health services:

‘If someone says to me, ‘where are you going?’[.....] I won’t hide it or anything [...] at the end of the day, I’ve got nothing to be ashamed of. If they’re going to cower away in a corner then that’s their issue not mine’ (Female, Northern Highland).

For others, it was about having the courage to be open about their mental health status, and risk being rejected, recognising that negative judgments reflected more about the other person:

‘I’m very open with it [.....] If you’re ignorant enough and you don’t want to know what a mental illness is and how to be a friend to a person with a mental illness then that’s your bag, you deal with it’ (Female, Northern Alberta).

In one focus group in Highland, a participant recounted a story in which he actively challenged a member of the public regarding her views on the mental health community:

‘Can I give a classic example of perception of mental health in this community [.....] There’s a woman who works at a local supermarket [...] she said, ‘there seems to be an awful lot of people with mental health problems here...I see them coming in to the store’, so I said, ‘[...] how would you recognise them’, she said, ‘well, they always have someone with them, helping them with their shopping’. I said, ‘now, hold on a second, are you not getting mixed up? There’s people with mental health problems in the community, and there’s people with learning difficulties [.....] which is completely different, separate, although these people might have mental health problems as well’ (Male, Northern Highland).

An active language also evoked notions of rights, both in terms of how service users treat each other and also how they would like to be treated by the wider community:

‘the ethos of [the other organisation I am involved with] is to be respected as an individual regardless of whatever mental problem [...] you may have [...] and to be accepted and respected in the community along with everybody else {and} I think that is practiced here as well’ (Male, Northern Highland).

For some, how they were seen by others was about dignity, about having their humanity
The idea of being perceived as a human being was about being confirmed and seen as an individual worthy of respect:

‘I always say, everybody in town here has the same feelings as we do, we feel hurt, we feel happy, we feel disgusted, we’ve all got the same kind of feelings, so why treat us differently’ (Male, Southern Alberta).

Such fundamental human values are particularly important in the context of mental health where stigma and discrimination have created a ‘struggle for dignity’ for service users (Lilja & Helzen 2008). Indeed, the recognition of service users’ humanity, the idea that there is something fundamental that they share with ‘ordinary people’ is essential for healing and regaining control (Eriksen et al., 2012).

This active language is arguably embodied in the ‘mad pride’ movement that has emerged in recent decades (see www.madpride.org.uk). The movement, originating in Canada in 1993, was initially inspired as a reaction against stigma and discrimination faced by service users. It followed on from movements such as ‘black pride’ and ‘gay pride’, bringing together activists, artists and intellectuals to ‘destabilize and reverse the binaries and hierarchies associated with mainstream psychiatry’ (Lewis 2013, p. 145). Specifically it meant reclaiming the language used by the non-mental health community to describe the mad (i.e. ‘crazy’, ‘lunatic’ or ‘insane’) (Reaume 2006) and to allow people to reframe their conditions and celebrate unusual ways of processing information and emotion (Jost 2009). Consequently, mental illness is reframed as something that should be cultivated and taken care of rather than eliminated or suppressed (Icarus Project 2013).

At its core, the message is simple: mental health problems are something to value, to be proud of and, equally important, they can be channelled in different ways. The reclaiming of madness in this way, and the channelling of mental health problems in diverse, constructive ways can be seen with the celebration of madness in terms of its artistic creative potential. The plethora of mad art events is testimony to this wide reaching influence (http://www.workmanarts.com/index.php/madness-and-arts-world-festival/; http://www.creativityandmadness.com/; http://www.mhfestival.com/; http://www.theteaparty.co.za/why/ ) encouraging all those affected by mental health problems to change their perspective on the meanings ascribed to madness.
The mad culture, therefore, is about an empowered identity involving an ‘active and thoughtful positioning of the self with respect to dynamic social narratives regarding mental difference and diversity’ (Shcrader 2013, p. 62). In terms of social inclusion policy, the implications are clear: mad culture is not about assimilation and the desire for homogeneity, it is about celebrating difference, encouraging the mad to reclaim their identity and transform their relationship to ‘the problem’ of mental ill-health. This reclaiming of madness has become increasingly influential (see Mental Health Foundation (2013c) ‘Don’t call me crazy, call me mad’), and indeed there is a strong campaigning element within the ethos of the movement (Wallcraft & Bryant 2003). Much of this resonates with the data from this study. For instance, capturing the voice of rural service users reveals this collective empowered narrative. In particular, there was a sense that participants were unwilling to subscribe to a victim identity, often challenging negative attitudes when confronted, or simply having the confidence to disclose to others their service user identity.

4.5.2 Sub-Theme 3B: Excluders as a Source of Inclusion?

The underlying imperative of social inclusion to encourage people to participate in mainstream society does not always sit comfortably with the experience of service users. Some participants in the study recounted experiences of trying to be part of mainstream society, of being rejected and consequently failing to be embraced by it, and of now having no desire to return to it:

‘I often feel that I wouldn’t necessarily fit in with mainstream communities. In some ways I wouldn’t want to be a part of them and in other ways I desperately would want to be a part of them. Sometimes being in this room, you feel so much safer and more comfortable because you don’t have to explain yourself, you don’t have to behave in the normal way […]. You can be free to be yourself – and that’s a different aspect of stigma, where you feel included amongst your own community and excluded by a large section of other communities. Not through prejudice but because they don’t understand or accept you’ (Male, Lower Highland).

For some, the rejection also came from professional sources:

‘I went to the hospital not so long ago for [something] and because they know I’m coming here […] I was treated like a second class citizen […] and that was through a doctor at the hospital’ (Female, Western Highland).
Such views highlight the problems associated with the policy in the context of mental health in that it ignores the divisions which create exclusion in the first place (Spandler 2007).

In the following extracts (Extract 2 and 3) participants highlight this rejection by mainstream society. The data illustrates that mental health and mainstream communities do not always integrate effectively.

**Extract: 2 (West Highland)**

**Male 1:** oh aye, we can talk to each other

**Researcher:** do you think in a way that you maybe couldn’t out in the mainstream, is there a difference?

**Male 1:** well I would in the mainstream but a lot of them in here won’t

**Male 2:** I’ve tried it in the mainstream but it doesn’t work very well

**Researcher:** why is that, do you think there is still issues with stigma in rural places?

**Male 1:** oh yes

**Male 2:** stigma and ignorance

**Female:** yeah if you say, ‘oh I’ve got a mental issue’ they think you’re crazy [...] they don’t realise that underneath that mental issue there is still a person, they do forget that we are just human after all, in here we can still be human as well as having a mental issue

**Extract: 3 (Southern Alberta)**

**Male:** when I first came here [...] I tried to get back into the society [...] I was going all over town, talking to people and trying to apply for jobs [...] but couldn’t get back into society. [I] felt from previous experience that it takes friends, community and a family to make a person well, so like I say, I started coming down here. We are family, friends and community here

**Researcher:** In terms of trying to get back into society, where do you feel you are now then when you come here…..do you think that this is a
part of society or do you feel that there is a mental health community that is different to mainstream society?

Male: I think so, they’re different......like one person put it to me......he was hanging out in the black community and he said ‘that didn’t work either’....you have to associate with your own kind

The above extracts reveal the way in which participants have attempted to integrate within mainstream social settings, as per the policy of social inclusion, but have been rejected by those in the mainstream who are taken to be unquestioningly inclusive. This represents a powerful tension for inclusion as a goal for social life because it locates the problem with the agents who are excluding (due to stigma and discrimination).

For some academics, the proliferation of drop-in centres have reinforced the segregated status of service users (both physically and symbolically), despite being located in the community (Repper & Perkins 2003). This suggests it can be difficult to find personal meaning and value in something that is devalued by the community. In the context of social inclusion, however, participant narratives from this study reveal the way in which such organisations represent a key source of inclusion (defined in terms of what service users need). For example, in Extract Three the participant talks about the importance of being amongst other mental health service users, amongst his ‘own kind’, as it allowed him the freedom to be himself (a consistent theme for participants in both Highland and Canada). There is a sense here that being accepted, or ‘included’, comes not from being part of mainstream society but from being amongst likeminded individuals:

‘when we’re with family or friends, who don’t understand, who are afraid of mental illness, you have to stifle it...but right here you can be who you are’ (Female, Northern Alberta).

The policy of inclusion advocates the importance of participation in mainstream settings as a route to inclusion but the data from this study indicates that this can potentially be a source of anxiety and stress for service users, not only in terms of trying to appear ‘normal’ but in the continual rejection that they experience by mainstream society due to their mental health status.

Within social policy discourse there is an implicit assumption that inclusion is necessarily good (Spandler 2007) and that everyone should want to be involved: the ‘dream of inclusion’ (Sayce 2000, p. 18). By implication, this suggests the mainstream is
effectively trouble-free and legitimate, which does not seem to be the case in terms of participant narratives from this study. As Levitas (2004) notes:

‘versions of social exclusion operate with a dichotomous model of society, insiders and outsiders. The significant structural break in the social structure is between those defined, by whatever criteria, as outsiders, and the included majority. The ‘problem’ then is how to help, cajole, or coerce the outsiders over some perceived hurdle into the mainstream. That division may be seen as a threat to social cohesion or as a moral disgrace. Attention is drawn away from inequalities among the included…As far as the ‘included’ are concerned, the implied structure is that of a meritocracy’ (Levitas 2004, p. 47).

The idea of legitimacy, of a ‘satisfied ‘included majority’ and a dissatisfied ‘excluded minority’ (Spandler 2007) presents a rather simplistic construction of contemporary social life, one that ignores evidence of on-going social fracturing (see the recent 2011 report by the OECD ‘Divided We Stand: Why Inequality Keeps Rising’ which found that the gap between the income of the top 10% and the bottom 10% in the UK has multiplied by 14 in the last 25 years). Furthermore, the policy of inclusion presumes that ‘normal’ people are ‘socially included’ in a variety of aspects of social and community life (Secker 2009). However, academics highlight the middle class practices (middle class taken here to encapsulate ‘mainstream society’) of exclusivity and maintaining privilege (Matthews & Hastings 2013) encouraged by a contemporary education market that facilitates class advantage and a differentiated system of schooling (Ball 1993; Ball et al., 1996). Indeed, middle class values of market, choice and individualism have increasingly taken priority over traditional values such as civic commitment and a sense of communal responsibility (Reay et al., 2008) suggesting this may not be conducive to current policy thinking around building inclusive communities (e.g. the Government’s ‘Big Society’ discourse). It also leads to questions around fairness, given that prioritising values such as individualism do not apply to mental health service users in the context of social inclusion. Furthermore, the growing gap between the rich and the poor has exacerbated class divisions and increased mistrust and fear of the classed and racialised ‘other’ (Reay et al., 2008). Finally, affluent gated communities can be considered a form of self-imposed exclusion that essentially keeps out all others who do not belong within such boundaries, a ‘concrete embodiment of the social segregation of the elite’ (Barry 1998, p.
8) leading to questions around who exactly is included and into what. Indeed, the idea of maintaining privilege beyond what the majority can afford, or having the means to voluntarily exclude (through living in a gated community) suggests two thresholds of social exclusion. The lower threshold consisting of ‘insiders’ who participate in mainstream institutions from those who are ‘outside’ of them, whilst the upper threshold is the one that divides those in the middle from those who can afford to detach themselves from mainstream institutions (Barry 1998). In this way, the situation is one in which a minority are in a position to exclude the majority.

For Levitas (2004) the idea of helping, cajoling or coercing the ‘outsiders’ can be linked with a moral underclass discourse (MUD) which is embedded within the policy of social inclusion. Within this discourse, the socially excluded are seen as morally distinct and lacking in the values ascribed to the rest of society; it focuses on the behaviour of the excluded (with a particular concern about the dependency of some on state benefits), whose failures and inadequacies are seen as the cause of their own exclusion, rather than on the processes of wider society (i.e. structural factors such as inadequate housing or a lack of amenities): ‘It’s important for my wellbeing that they leave me alone, so to do that I do a very small amount of paid work’ (Male, Lower Highland). From this perspective, the socially excluded are seen as lacking in the skills and dispositions necessary to participate in mainstream activities: ‘[coming here is empowering] instead of someone dictating to you what you can and can’t do, and kind of patronising you as well, which I really dislike’ (Male, Western Highland). Fundamentally, the structural barriers that inhibit participation are not the problem, it is cultures of low aspiration and fatalism (Fairclough 2000), a ‘poverty of opportunity’ (Levitas, 2004, p. 48). Social inclusion therefore requires the adoption of specific values and attitudes. In the context of mental health, the drive to ‘include’ can, therefore, potentially amount to moral and social regulation through goals which are set by government and policymakers, and which, in turn, can lead to those who do not co-operate being viewed as dysfunctional (Spandler 2007): ‘I’ve always had a feeling […] I don’t get as good a service as I might because I’m not humble enough dealing with the staff’ (Male, Lower Highland). Indeed, social inclusion as a policy driver can be seen as representing a form of expert knowledge.

Concerns with moral and social order were discernible with the work of the Social Exclusion Unit (SEU) which was set up shortly after New Labour came to power in 1997. As Levitas (2001) notes, ‘key reports [from the SEU] address(ed) rough sleeping (but not homelessness); truancy and school exclusions; teenage pregnancy (including 18 and 19 year olds who are legal adults); problem estates; and young people not in education or training. Two key groups were targeted as socially ‘delinquent’—truants, deemed to be potential criminals, and teenage mothers’ (Levitas 2001, p. 452).
and power that is arguably at odds with genuine collective empowerment and self-determination (Spandler 2007). As the findings from this study have shown, attempts to assimilate within mainstream society have often been unsuccessful for participants. Moreover, having a sense of belonging and connection, and being able to take part in activities was achieved within their respective mental health communities. In this way, the empowered language of participants (see Sub-Theme 3A) suggests that empowerment comes from connecting with likeminded individuals; social inclusion, therefore, can be about having opportunities to connect with others within mental health communities.

4.5.3 Sub-Theme 3C: Reconceptualising Value

The importance of capturing service user narratives, and their implications for policy, was also highlighted in one focus group in relation to labour market participation. In particular, it was noted the way in which having a job can be challenging for service users, essentially capturing the complexity of the situation and the challenge for governments in finding a solution:

‘you present only on a good day [but] you still can’t get a job because you have your bad days which your employer wouldn’t put up with’ (Male, Lower Highland).

Nevertheless, in terms of feeling productive, discussions around this offered a reconceptualization of value, in particular not simply equating being productive with labour market participation:

‘Even if you’re not doing voluntary work, if you’re a parent to someone, or if you support another person as a friend, isn’t that important and valuable, or if you do art work or something like that’ (Male, Lower Highland).

‘I mostly do voluntary work but I do a small amount of paid work […] I’m not so bothered about money, it’s the fact that I avoid a lot of hassle for me to go into paid work […] my employment is a tiny part of what I do, actually, if anything, it’s a minor irritant. That’s why they leave me alone, they don’t care about all the voluntary stuff’ (Male, Lower Highland).

Within the social inclusion discourse, elements of ‘normalization’ are discernible, reflected in notions such as social integration. As highlighted in the literature review, by implication it suggests the mainstream is functional, desirable and essentially trouble-free. Within this paradigm a binary mode of ‘desirable’ versus ‘undesirable’ is set up; the
desirable category representing paid work, being normal, having access to services, having opportunities to engage and participate, whilst the undesirable is conceptualised as the opposite. However, in capturing service user narratives (around what it means to be ‘productive’), it can be seen that this offers a more nuanced understanding of what is considered to be of value or desirable (by those who experience mental health problems), one that in many ways challenges the current dichotomous thinking in mental health policy. For example, the preoccupation with labour market participation as a signifier of inclusion, reflecting wider neo-liberal concerns with promoting personal responsibility, is challenged by service users on the grounds that being productive is not simply about whether a person has a job, or how many hours they put into that job. Indeed, as the quote above highlights, doing a small amount of paid work enabled one participant to meet his obligations and to avoid hassle from officials, whilst at the same time allowing him to do what really matters to him, in the form of voluntary work.

For others, the impetus to get a job was compromised by the reality of what it means to live with a mental illness; its unpredictable nature meaning that being able to perform work on a regular basis becomes untenable:

‘you have your bad days which your employer wouldn’t put up with, particularly with my kind of illness’ (Male, Lower Highland).

Others also highlighted the lack of free will in terms of being ‘fit’ for work:

‘it’s not like I’ve made this decision, ‘oh I just don’t feel like I can work’, it is dependent on the environment and the situation’ (Female, Lower Highland).

The disjuncture between what service users consider valuable and how it is framed in policy is important because it highlights that current policy thinking is not entirely aligned to what service users want or need. Some academics have recognised this and have done innovative work around other sites that can facilitate inclusion (see Secker et al., 2009, and Parr 2005). Such work highlights the ways in which productivity and inclusion are combined in spaces that have meaning for service users, outside officially sanctioned indicators.

The idea of paid work as the primary means of social inclusion tends to uncritically present this as an ideal of social life. However, such a premise pays little attention to the problems of work under contemporary capitalism such as in-work poverty, low wages and short-term insecure working arrangements (Levitas 2004) which may be no better for
health than unemployment (Benach et al., 2002).\textsuperscript{21} Furthermore, as the quotes above highlight, the centrality of paid work within social inclusion policy undermines the legitimacy of non-employment (Levitas 2001), ‘work’ in the context of social inclusion is essentially restricted to market-based activity. Furthermore, achieving employment for service users can sometimes be about providing positions that no one else wants. Examples of leaflets asking employers if they have posts in their business that were ‘hard to fill’ and that ‘no one wants’ (Repper & Perkins 2003, p. 134) suggests that quantity, not quality, is central to employment indicators.

As highlighted by the literature review, employment rates of disabled people are low (Smith & Twomey 2002) with 45.9\% of working age disabled people economically inactive (this figure is 2.5 times higher than that of non-disabled people (17.8\%) (Papworth Trust 2012). This represents the largest group of working age benefit claimants (Clayton et al., 2011). In order to assist people back into employment in the UK and to reduce the costs of incapacity-related benefits (or Employment and Support Allowance (ESA) as it is now called), the Coalition Government has brought about a number of welfare reforms and established a single ‘Welfare to Work Programme’ designed to help those who face significant barriers in terms of accessing employment (Department of Work and Pensions 2013). However, data from the current study reveals that available support to help service users gain employment was found to be rudimentary and not adapted to individual need:

‘For a long time, on paper, there’s been support available for people to do whatever they need to get fit for work again but in practice these things are very crude and not tailored to individual needs at all’ (Male, Lower Highland).

Moreover, a closer examination of such ‘help’ reveals that there is increasing compulsion, coercion and benefit sanctions for non-compliance (Levitas 2004)\textsuperscript{22}. For some, there was also a sense of blame regarding welfare reform: ‘in terms of the system, the cutbacks are all claimed to be our fault’ (Male, Lower Highland). In the context of mental health, such coercion has significant implications. For example, the private company hired by the government to administer Work Capability Assessments, Atos, has come under heavy criticism for ruling that individuals were fit to work in some cases

\textsuperscript{21} Figures from the Health and Safety Executive (HSE) labour force survey for 2011/12 found that 428,000 individuals experienced work-related stress, with an estimated 10.4 million working days lost per year

\textsuperscript{22} As part of the crackdown on welfare dependency the present Coalition Government has more than tripled the number of punishments enforced against failing jobseekers across all its schemes. The number of cases has risen from 139,000 benefit cuts under New Labour in 2009 to more than 500,000 in 2011 (Boffey 2012)
shortly before they died. Others have committed suicide due to the outcomes of the assessment system (Gentleman 2013). Indeed, such assessments have been described as ‘not for purpose’ by the British Medical Association because they involve a computer-based system of checklists that have little regard for the complexity of the needs of the disabled and the sick (Meacher 2013). In relation to mental health problems, such a flawed assessment system may be particularly limited due to the fact that symptoms for mental illness may not manifest themselves in dramatic physical ways. To add to this, misdiagnoses are a significant factor in the mental health field (Pérez-Stable et al., 1990; Selten & Hoek 2008; Lawn et al., 2010). In this way, an assessment system that is rigid and limits the ability of professionals to exercise their judgement presents a challenge for an area that requires clinicians to work (on a one-to-one basis) with the subjective reports of the service user in order to make a diagnosis:

‘the people that are making these assessments are not trained. I think it would be fair if the assessment could be made by a psychiatrist and your actual GP, who actually know you than some person who is not very well trained, and in a very short interview’ (Male, Lower Highland).

As the above discussion highlights, the potential of getting it wrong can ultimately have extremely negative consequences and lead to further stress and anxiety for those who may already be dealing with considerable stress due to their mental health problems.

This sub-theme (3C) is important in the context of social inclusion. In particular, participants draw attention to the many ways in which they can feel ‘productive’ outside traditional indicators (i.e. labour market participation). Moreover, responses from participants reveal the challenges of finding and maintaining work due to the sometimes unpredictable nature of mental illness, coupled with an inadequate benefit assessment system. It is also worth noting here that these responses are framed within a rural context. By implication there may be considerable challenges in actually finding meaningful employment given the limited options and lack of choice that is inherent to rural areas.

4.6 Chapter Summary

This chapter has sought a deeper understanding of the role of rurality in shaping the perceptions and experience of mental health service users. The study findings indicate

23 In one recent study bipolar disorder was misdiagnosed as depression in over a quarter of cases (Royal College of Psychiatrists 2009b).
that stigma forms part of their everyday experience and makes it difficult to forge friendships or make new connections. The close-knit nature of rural communities can also mean that maintaining anonymity as someone with a mental health issue is challenging. Stigma was more pronounced in Highland, possibly due to wider cultural norms that emerge from communities that are much older in origin compared to Canada. However, the picture is complex. Whilst rural dwellers can be unforgiving of difference, many participants still felt an affinity with rural places and these engendered a sense of belonging for them (closely aligned to idealised notions of rural living). This was reflected in patterns of intra-rural and rural-return migration although the reasons for migration differed across countries. In Highland, migration was motivated by the need to get away from difficult situations or because of the lack of privacy. In Canada, migration was often due to a lack of services and was therefore resource driven. Additionally, analysis of rural service user narratives reveals a rhetoric-reality gap and highlights that current policy thinking is not necessarily aligned to the needs of rural service users.

Therefore, the chapter has answered research question one ‘What does it mean to experience a mental health problem in a remote and rural area?’ and shown that:

1. Stigma is more pronounced in the Scottish Highlands than it is in Canada.
2. There is considerable migration amongst the mental health community, and the drivers for this differ by country.
3. There is a disjuncture between mental health policy (i.e. social inclusion) and the lived reality of rural service users.

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24 There is currently a lack of available data on in-migration and mental health in Alberta to assess how prevalent this is around the province
CHAPTER 5

THE CHALLENGE OF DELIVERING MENTAL HEALTH SERVICES IN REMOTE AND RURAL AREAS: A COMPARISON OF HIGHLAND AND CANADIAN PROFESSIONALS
5.1 Introduction: The On-going Challenges for Rural Service

In this chapter, a number of themes are presented in relation to delivering mental health services in remote and rural areas. Whilst Chapter Four combined data from the service user focus group discussions and the service provider interviews, this chapter is concerned with the points of similarity and divergence between what service providers only reported (see Table 2 for a breakdown of service provider occupation in each country).

The following chapter explores five broad themes and associated sub-themes that emerged from these interviews. These themes were identified due to their degree of recurrence within the transcripts. Theme One and Theme Two (see below) in particular were central issues for providers and are therefore presented first in order to demonstrate this importance.

The chapter starts with issues around rural service design (Theme 1 ‘Rural Service Design’) and how perceptions differ between professionals in Highland and Canada (Sub-Theme 1A: ‘The Challenge of Delivering to Dispersed Populations’). A further issue specific to Canada is highlighted in Sub-Theme 1B (‘First Nations People: colonialism and its reach in the modern landscape’) in relation to First Nations people and some of the cultural challenges for service providers. Theme Two (‘Recruitment and Retention: on-going issues for Scottish and Canadian rural professionals’) centres on issues in relation to the recruitment and retention of rural health professionals, findings which resonate with the wider literature on the subject (see section 2.4). Theme Two is broken down into the Sub-Themes: 2A) Rural Practice; and 2B) Training of Rural Mental Health Professionals. The third theme (Theme 3 ‘Collaborative Rural Working’) focuses on collaboration between health professionals in rural areas, linking with the current policy thinking in both Scotland and Canada. Theme Four (‘Service Resources’) explores some of the on-going issues for service providers in relation to resources and what impact this has in terms of being able to deliver efficient mental health services. In the final theme (Theme 5 ‘Role of Voluntary Organisations in Rural Mental Health Service Provision’) the contribution of the voluntary sector is explored in terms of how this fits with overall service provision in rural areas. As previously noted, there is limited knowledge on the contribution of the rural voluntary sector. The findings presented in this chapter, therefore, offer an important contribution to the knowledge base.
As noted in Chapter Two (see section 2.4), whilst available studies offer evidence around the barriers that rural dwellers face in accessing health care, less is known about perceptions of rural service providers (Brems et al., 2006). Moreover, whilst there are common issues in relation to developing an effective rural workforce, there are issues specific to mental health professionals (Moore et al., 2010) but yet these voices are largely missing from the literature. The following chapter, therefore, address this gap in the literature.

5.2 Theme 1: Rural Service Design

Theme One has an overarching focus on perceptions of how rural mental health services are designed. This theme is particularly important given the challenge of providing effective services to dispersed populations and indeed, as the literature has shown, mental health support in rural areas remains poor. This section is made up of Sub-Themes: 1A) The challenge of delivering to dispersed populations; 1B) First Nations people: colonialism and its reach in the modern landscape.

5.2.1 Sub-Theme 1A: The Challenge of Delivering to Dispersed Populations

Delivering and maintaining effective health care in rural areas can be problematic given the vast geographical areas that professionals have to cover, coupled with uncontrollable factors such as weather (Bull et al. 2001). In addition, rurality is associated with lower population density and scarcity of services (Weller 2005), and is often accompanied by shortages of qualified professionals (Curran et al., 2006), transport difficulties, long waiting lists and lack of after-hours services (Moore et al. 2010). Changes in the economy of rural areas, along with demographic factors such as an ageing population and the out-migration of younger people (Godden 2005), also combine to create a unique set of challenges in delivering health care compared to those in urban areas. However, data from the current study evidences cross-national differences in terms of how rural mental health services are designed. Canadian professionals generally felt that the provincial government designed services in a way that accommodated rural factors such as time, distance and small populations:

‘I know University of Calgary, with the outreach to the north to train social workers from the Aboriginal communities....they’ve gone out of their way to make sure that the training is offered in smaller communities and they pay the people to go out there and do the training’ (Counsellor, Alberta).
‘I know they’ve lost some hospitals over the years but for mental health….I think, if there’s a need, if there’s a squeaky wheel somewhere they’ll find a way to cover for that’ (Intake Coordinator, Alberta).

Examples illustrated how resources had been provided to facilitate delivery of care locally:

‘where they don’t want to make the drive, the clinic have been wonderful by just giving me the resources to work with […] they’ve given me what I need to support [clients]’ (Counsellor, Alberta).

In contrast, Highland professionals felt that rural areas were generally seen as less of a priority for policy makers, particularly in relation to infrastructure:

‘unless a person is willing, and can travel to Inverness, that service is not available’ (CPN, Highland).

‘my colleagues in Inverness are able to provide memory stimulation groups [but due to] geographical constraints and because I am just one, it’s just not possible to do that’ (OT, Highland).

‘I’m trying to set up [a support group for carers and clients] within East Ross because again they don’t have anything […] There’s nothing on the Black Isle. The Black Isle for some reason is very badly served’ (OT, Highland).

Moreover, Highland professionals felt that the added burden of travel was not accounted for in overall service planning:

‘[in terms of distance and small populations] the time it takes, and how many people you can see as a result of how long it takes to get there, is certainly a valid one and I don’t think it is recognised in the same way. Whereas I could maybe see six or seven folk if I live in Paisley because my furthest journey would be about four or five miles […] here I can take an hour and a half getting to somewhere, and then the same time getting back’ (MHO, Highland).

‘When services are being looked at [planners don’t] take into account transportation […] this whole transportation cost is a real problem […] Just as every month I’m having to put in my mileage claim […] year upon year those costs haven’t been accounted for within the provision of the service’ (OT, Highland).
Within the rural health professional literature, travelling significant distances in order to provide care is well recognised (Bourke *et al.*, 2004; Brems *et al.*, 2006; Moore *et al.*, 2010). In Scotland, the government has recognised the importance of equity of access as well as the challenges of providing healthcare to remote and rural populations (Scottish Government 2002). Policy documents such as *Services in Rural Scotland* (Scottish National Rural Partnership 2000) have sought to provide flexible solutions, including proposals to encourage the shared use of staff, buildings and vehicles in order to reduce the high unit cost of service provision. However, based on the findings from the study, it can be seen that such issues are an on-going concern for rural mental health professionals in Highland, suggesting that solutions to rural travel have not yet been achieved. In this way, the rhetoric and reality do not match.

5.2.2 Sub-Theme 1B) First Nations People: colonialism and its reach in the modern landscape

A key finding from the study, specific to Canada, centred on the issues associated with delivering services to the indigenous First Nations population. Some of these issues centred on geographical location, with reserves being located in remote and hard to reach places, creating considerable problems with access:

‘Oh I think there’s a lot of challenges for [First Nations people] accessing the services that they need and a lot of it is how remote some of the reserves are, very remote, like quite a long drive to get anywhere’ (Counsellor, Alberta).

There were also a number of social factors, such as violence and general impoverishment, that were found to inhibit professionals from providing services due to perceptions of those sites as dangerous:

‘[professionals] don't want to go to the reserve because they don't feel safe. There's no street signs [...] so it's easy to get lost [...] you have to be comfortable because you have to get out of your car and knock on people's door and ask, ‘where does Joe live?’ [...] There are a lot of professionals who are just feeling unsafe because they have this kind of stereotypical image that makes them worry, if they get out of their car they might get mugged, or raped, or whatever’ (Psychologist, Alberta).

Other First Nations issues centred on their higher risk/incidence of suicide:
there’s so much suicide on the reserves [...] it’s like three times what it is for the rest of the population’ (Counsellor, Alberta).

A possible explanation for this came from one focus group participant (of First Nations descent) as she noted the lack of awareness around mental health problems:

‘one thing that I would like to voice [...] mental illness in the First Nations community is not recognised well’ (Female, Northern Alberta).

Within the context of suicide (see Chapter 3) there is an increasing recognition of the need for culturally sensitive prevention and intervention strategies that attempt to reconcile these two standpoints (Isaak et al., 2010). An array of guidelines and reports has been produced that specifically address the needs of the Aboriginal population (Health Canada 2003; White & Jodoin 2003; Kirmayer et al. 2007; Canadian Institute for Health Information 2009). Given the scale of the problem, such attempts are important and reflect a growing concern at a national level around the most effective ways to deal with the issue of Aboriginal suicide. However, efforts to delivery culturally-sensitive suicide interventions do not always meet with success because of a lack of coordination. One professional in the study highlighted the lack of joined-up working between services in relation to suicide prevention training to help indigenous people. Based on her own experience, it was noted that despite considerable effort in putting together a culturally sensitive package, it had failed to be used due to some members leaving the committee and those positions not being replaced. As a result, the material remained unused despite the high rates of suicide within the First Nations population.

In terms of providing services to First Nations people, it was not uncommon to have problems with initial contact with someone from the reserves until trust had been established:

‘the first meetings are always tricky because they’ll agree for me to come and meet with them and I’ll come, and they’re not there....and then I have to keep phoning, and we play that game...but I’ve been on the reserve a lot so I’ll know to track them down at the coffee shop, or at a cousin’s house or something....then after they meet me the first time, then it’s okay...but the first visit can take often a month’ (Psychologist, Alberta).

This example demonstrates some of the cultural barriers that providers can face (particularly ‘white’ outsiders) in trying to engage with service users.
There were also intra and inter reservation differences in terms of their social constitution:

‘the […] reserve, south of Edmonton, there’s a lot of violence on that reserve in particular, more so than a lot of the other ones…..and yeah I think there is probably a reluctance of some [to initiate help]’ (Counsellor, Alberta).

‘there will be so many different ideas about what they want or need, so they can’t come to an agreement ……one person will say, ‘you’re welcome to come out’ and then you go out there and they’re like, ‘well we didn’t really want you here’…..so there’s a lot of cross purposes’ (Counsellor, Alberta).

First Nations reserves are often located in rural and isolated areas. As a result, it can often create barriers in terms of accessing health care. For health services that are available, evidence suggests that long waiting lists coupled with care that is not culturally appropriate, serve to create an inadequate system for those living on reserves (Reading & Wien 2009). In terms of mental health, current service provision does not meet the mental health needs of Aboriginal people (Alberta Mental Health Board 2006, p. 5):

‘they usually just stick [them] in a hospital or mental institution […] they don’t have a place to go’ (Female, Northern Alberta).

Despite recommendations for mental health services to be available close to where people live (Premier’s Advisory Council on Health 2001) there remains a dearth of specialist services available within easy reach for those living on reserves. Moreover, apart from disparities in terms of geographical location, the quotes above highlight the cultural challenges facing service providers.

5.3 Theme 2: Recruitment and Retention: on-going issues for Scottish and Canadian rural professionals

The second major theme in this chapter focuses on the issue of recruitment and retention of rural mental health professionals. As the findings from Chapter Four highlight, high visibility combined with prevalent gossip networks create difficult circumstances for rural service users, potentially discouraging others from coming forward and seeking help for fear of being identified as mentally ill. However, as the first sub-theme in this section (Sub-Theme 2A) highlights, this can also be challenging from a professional standpoint. In such tight-knit communities it can often be difficult for professionals to maintain clear boundaries between their public and private life (Alan et al., 2008) when living and
practicing in the community (this was the case for professionals in both Highland and Alberta). Indeed, the data reveal that some professionals have moved further away from where they practice in order to maintain their privacy and/or professional distance and impartiality. There were also clear issues for providers in both countries in terms of professional isolation and the lack of opportunities for professional development, again consistent with the wider literature (see section 2.4). Theme Two is broadly concerned with some of the problems of practicing in rural areas and is made up of the following Sub-Themes: 2A) Rural Practice; 2B) Training.

5.3.1 Sub-Theme 2A) Rural Practice

In discussing the drawbacks of practicing in rural areas a number of professionals highlighted the issue of being known within the community, even when they were not working:

’I don’t live here but I’ve worked here long enough…so there’s nowhere I can go that I won’t run into clients because I’ve served so many people over so many years' (Counsellor, Alberta).

In this way, there was no clear separation between their personal and professional life (Ball et al., 2008). Various solutions, such as living further away from the community, had been deployed by some as a way of dealing with the overlap between the public and the private domain:

’I’ve chosen to stay out of the town, I live in a small village, but I always find it quite uncomfortable, and I’ll probably have to get use to it, bumping into people that you see….but there is something about the fact that you have less privacy…because people know each other in rural areas’ (CPN, Highland).

Nevertheless, chance meetings within the community were seen as problematic when they involved questions about clients or resources; again making it difficult to maintain clear boundaries and separate roles (Brems et al., 2006):

‘once a service is provided to one […] it’s like, ‘oh do you think you could come and see so and so about that too’ (OT Highland).

For a number of professionals, the overlap between the public and private domain was quite uncomfortable and they felt this could potentially deter others from coming to
practice in rural areas. Professionals whose own origins were remote and rural tended to find this easier:

‘to me it would be very hard [coming from an urban area] but I think some of [my clients] kind of knew me around town, knew that’s what I do, they might not have grew up with me or they might not have had family here [but] everything is confidential’ (Intake Coordinator, Alberta).

However, there were advantages to practicing in rural communities in both contexts. Examples were given where the client had readily agreed to have someone they were familiar with to counsel them because they knew them and trusted them. Additionally, discrepancies between client stories and reality were easy to identify. Nevertheless, there were instances recounted in which clients were known to the professional in their personal life, e.g. through various community associations, making professional engagement with them difficult:

'[the community] know me through other organisations such as Minor Hockey, for instance, or my wife owns the gym here in town […] so some of the members there I know have phoned [to me] it's hard' (Intake Coordinator, Alberta).

In addition, counselling and dealing with more personal aspects of rural dwellers’ lives was found to be challenging for one Canadian professional:

‘one time a couple got referred to me and he helped with baseball and I helped with baseball, and his wife helped at the school and I helped at the school, so I knew her from school council and I knew him from sports, saw both of them equally, and they were having marital issues and so I said, ‘can I please refer you on because I just feel quite uncomfortable because I know you both so well, this would be awkward for me’ and they were okay with that…..so it can work both ways’ (Counsellor, Alberta).

The implications of working in rural areas also meant that professionals often felt isolated in terms of accessing expertise or peer support. For some, this was more about perception:

‘I feel less part of it [practicing rural] I can’t quantify why that would be but I just feel a bit more on the periphery of things because I’m further away’ (MHO, Highland).
This Mental Health Officer (who had worked in both urban and rural areas) felt that urban practice afforded more frequent, informal contact with colleagues due to closer physical proximity:

‘in Paisley we used to meet far more frequently as MHOs, as a group, because geographically we were always so close’ (MHO, Highland).

Distance from colleagues made it more difficult to share knowledge and talk about cases. In both Highland and Canada, efforts were made to bring colleagues together via technology, such as video conferencing, and regular meetings. However, the costs and effort involved meant these were not always perceived to be suitable alternatives. In some instances, it was found to take something away from the spontaneous encounters that happen in urban practice:

‘[formally meeting up] it’s the best part of a day which gets taken up…..and I think there’s benefit in people being able to meet on an informal basis and talk about things’ (MHO, Highland).

The physical geography of rural communities can mean that inhabitants are far more likely to encounter each other compared to those in large, urban places. Consequently, people have multiple relationships with one another (Schank & Skovholt 1997) i.e. they may be connected through a range of formal and informal community links. However, in the context of health services delivery, such an overlap can potentially create ethical dilemmas for professionals. If a professional chooses not to see someone they know, it may require the person to travel considerable distances to access other help (Erickson 2001). When a professional does take on someone they are familiar with, there may be added concern over having to report information to authorities (Ball et al., 2008):

‘The most awkward situation I had [was] a young girl come who’d been in a car accident that she caused, where serious damage was caused to the people in the car……I saw her at 10 in the morning, for [the] afternoon my client was one of those seriously hurt in the car accident…this was obviously going to go to court and by then I felt like I couldn’t see either of them…..because if I was called to court, I would potentially be putting either case at risk of being thrown out because of biased opinion’ (Counsellor, Alberta).

The aforementioned issues such as the overlap between the private and public domain and professional isolation suggest that practicing in rural areas can pose a number of
challenges for service providers. Indeed, the available evidence suggests that recruiting and retaining professionals in rural areas remains a significant problem, which has led to a shortage of health care professionals (Breton et al., 2005; Richards et al., 2005; Thomas et al., 2012). As the quotes above demonstrate, working in rural environments can potentially be isolating, with little opportunities for connecting with peers. When such opportunities are available, it often requires a significant commitment in terms of the time and distance to meet with others and with a shortage of staff, the vicious circle continues.

In the wider literature, professional isolation is considered a crucial issue in terms of attracting health workers to rural areas (Curran et al., 2006). Within the current study, a number of professionals belonged to community mental health teams consisting of various allied health professionals. In this way, some of the issues of professional isolation were negated through having contact with, and working alongside, professionals from other disciplines. Nevertheless, opportunities for drawing on discipline specific expertise remained limited.

5.3.2 Sub-Theme 2B) Training of Rural Mental Health Professionals

The data revealed that opportunities for professional development were increasingly restricted due to the current economic climate. Nevertheless, for Canadian professionals, technology was used as a way of reaching professionals in remote and rural areas. Examples of this included getting professionals together in one room to allow them to participate in virtual workshops:

‘you go to a physical location and they have a video camera linked to a guest speaker in an actual workshop and the video camera linked to you, so they can see you and you can see the audience….and it’s live, you can see the presenter, you can ask questions’ (Psychologist, Alberta).

The University of Calgary was also instrumental in providing high quality training through its Social Work faculty. For First Nations professionals, the faculty also provided a number of programmes to train service providers located on various reserves:

‘you can take the entire course online now […] through the University of Calgary, the Social Work faculty, they have a programme that works in the rural and northern areas, particularly with the Aboriginal population, and training social workers from the different reserves and the different areas’ (Counsellor, Alberta).
There were also regular conferences in Calgary that brought professionals together:

‘I think we’re pretty blessed because the University of Calgary brings in quite a few really good people […] the Alberta College of Social Workers has a conference every year, the Psychology Association has a conference every year […] so I think there’s a lot of opportunities for training’ (Counsellor, Alberta).

In contrast, Highland professionals felt increasingly limited in their ability to attend training courses. Whilst training related to new service delivery was expected, it was generally felt that innovative training related to enhancing discipline-specific skills was considered low priority and was therefore not allowed. This essentially limited opportunities for networking and peer support:

‘Any funding for training has gone out of the window, we don’t get any training that costs money or that takes you away for the night from your area’ (CPN, Highland).

A further dimension centred on the way in which training opportunities were generally offered around the central belt of Scotland (i.e. Glasgow and Edinburgh):

‘my biggest bugbear is that people will not come north’ (OT, Highland).

‘…for about a year, I had the chance to go to conferences […] but it meant that it was either in Glasgow, Edinburgh or Aberdeen […] but we’re not given the opportunity now because you’re away for two days’ (CPN, Highland).

Having to travel lengthy distances for training also caused disruption to work and family commitments (Curran et al., 2006):

‘I share responsibility for my granddaughter….so if you’re expected to be away, I then have to find a child-minder […] it just makes it very difficult’ (OT, Highland).

In these quotes there is a sense that the isolation professionals feel is further compounded by a lack of equity around training opportunities. To add to this, the recognition that the training needs of rural health care professionals differ from their urban counterparts is something that is only just being realised in the UK within the last decade (Godden 2005). The quotes above highlight that, in Canada, institutions such as the University of Calgary play an important role in delivering appropriate training for professionals working in remote and rural areas of Alberta. Nevertheless, despite one fifth of the population living in rural areas (Human Resources and Skills Development Canada 2013) most Canadian psychology students receive no formal training or exposure to rural
practice settings (McIlwraith et al., 2002), essentially creating a gap between the available training models and the demands of rural settings.

To overcome the barriers of professional isolation and limited training opportunities, innovative solutions such as greater use of technology are increasingly recognised as key in terms of connecting rural professionals (Scottish Government 2008; Ministerial Advisory Council on Rural Health 2002). Examples such as virtual workshops provide opportunities for professional development and for collaborative learning that mitigate some of the issues mentioned previously. As the quotes above reveal, Canadian service providers in particular noted the myriad ways in which technology has been used for professional development. However, it is unclear why technology is not used in the same way in Highland. The University of the Highlands and Islands (UHI) has over 70 learning centres located across the region that could potentially be used to deliver support and training to remote professionals.

At a policy level, both in Scotland and Canada, the use of telehealth has become a central feature of rural health service design (Scottish Government 2011b; Canada Health Infoway 2011). For rural patients, the use of technology in facilitating health care ensures more equitable access by allowing them to receive services in a community setting. For professionals, telehealth has important implications in terms of recruitment and retention given that it can facilitate professional networking and continuing professional education (Moffatt & Eley 2010). At a local level it can also enhance expertise within the community (Jennet et al., 2000). One of the largest telemedicine programs in Alberta is called telemental health. Whilst the program has increased access to mental health services overall, this has been particularly so for service users in rural areas (Alberta Health 2008, p. 9). However, this does not always provide a suitable alternative to face to face engagement. As highlighted by the findings, some providers felt that using technology to connect rural professionals created more formal communication than what would have been preferred. Additionally, using telehealth for psychiatric consultations was noted by one Canadian professional to have been a failure in some instances, in part due to a lack of training, suggesting that there may still be some way to go before delivering psychiatric care in this way is accepted as equal to face to face consultations.

5.4 Theme 3: Collaborative Rural Working
Despite issues around professional isolation in cases where professionals were part of community teams, there was evidence of positive collaborative working. Sharing information with others in the team meant a greater sense of unity and cooperation. Such collaborative working meant that members who had attended training fed back to the team, thereby allowing others the opportunity to share in professional development:

‘we’re not precious within the team [...] I get the emails [about training] just the same as my colleagues [...] when I get stuff that’s OT sourced, I forward that on to my colleagues' (OT, Highland).

In some instances, simply having good relationships with professionals in other services was crucial for accessing the right information about a client, or knowing who to refer a person to:

‘our Housing Officer [...] he’s really crucial [...] in giving us right information about what somebody’s housing situation is....because he has this direct link into the council’s housing office. So he’s very important for us' (CPN, Highland).

As one professional highlighted, collaborative working was about getting to know professionals from other services, building up good relationships so that community mental health services worked efficiently:

‘[in terms of collaborative working] I get the most referrals from physicians that I’ve actually sat and talked with. They recognise my face, we have a talk [...] they weigh up whether they like me, if we think along the same lines about health, if we have the same perspective' (Psychologist, Alberta).

Indeed, some professionals felt that this sense of connection was missing in urban practice:

‘one of the great advantages in a rural area is that you tend to get one consultant per sector and as a result you can develop very good, close working relationships with that consultant. Whereas in an urban area...I mean in Paisley there would be seven or eight consultants and I wouldn’t know who would be the person ’ (MHO, Highland).

Some providers had also got to know other professionals in the private domain and had established good friendships as a result. This was found to be important in terms of developing trust and rapport:
'[in terms of collaborative working] two of the physicians I know very well from golf and coaching hockey with [...] there's kind of a trust factor that if something comes up, we'll look after it. So we have a very good rapport with them’ (Intake Coordinator, Alberta).

‘My experience is that, I think in Invergordon there are better links with community mental health teams. It’s kind of more informal and I think it’s more supportive. In Inverness it seems to be….I think it’s just because it’s a bigger area, you know; it’s a city…and I think we don’t have that same relationship’ (Voluntary Organisation Manager, Highland).

In addition, it was generally felt that rural practice involved going over and above professional remit:

'[in rural practice] there's nobody else to do it […] you've got to see it through from beginning to end' (OT, Highland).

Or, in some cases carrying out tasks that were below grade:

‘You cover all grades…..you do everything underneath your grade too’ (CPN, Highland).

In this way, rural practice was conceived as more holistic in terms of the role of the professional:

'in rural areas, I think our roles merge much better and blur much better. For example, I'm just as likely to be refer someone for anxiety and dementia as my CPN colleague would be [...] I think the team I work with are much more aware of my skills and similarly me with them' (OT, Highland).

Such quotes highlight some of the unique elements of collaborative practice in the context of rurality.

In both localities collaboration was important for providing rural mental health services:

'I think generally there is good collaborative working [...] we don't have a consultant psychiatrist in Older Adults or Younger Adults based down here, they come down once a week and so we have to make arrangements in advance to make sure they're going to be coming down to see people we want them to see [...] So, consequently, you have to have good working relationships with people’ (MHO, Highland).
'even when I was in […] I went to the Home Care meetings […] got to know them face to face. I got to know the Child Welfare workers and I would go over to their office too and, of course, it would be face to face […] so if there was mental health issues […] they would phone and we would set up appointments for the kids’ (Intake Coordinator, Alberta).

However, it was also felt that working collaboratively required an open-mind, given that other professionals and agencies are trained within a particular theoretical framework:

'I found other professionals really keen on collaborating and quite helpful. I think maybe 10 years ago, it was pretty new for, say, a counsellor to collaborate with a physician, or a psychiatrist…I mean typically, professionals from each discipline are trained….their theoretical framework is slightly different…..so even to collaborate you have to be very open-minded and accepting of different theories' (Psychologist, Alberta).

In some instances, it required a concerted effort to work through professional differences:

'we’ve done packages before where we’ve worked with other agencies, and sometimes there are differences in terms of policies and procedures, and basic values really…and that can be….well it has to be worked out’ (Voluntary Organisation Manager, Highland).

The theme of collaborative rural working is particularly salient in the current policy context. In both Scotland and Canada, rural health services are facing significant problems, including an ageing population and a shortage of personnel (Scottish Government 2008; Alberta Health 2008). In order to meet the challenge of providing sustainable community health services in an era of significant budget cuts, the emphasis in both countries appears to be on strengthening collaborative and integrative working for the rural health workforce. In Scotland, as part of its reform of the public sector, the government has moved towards a preventative approach in public health and has placed greater emphasis on collaboration at a local level in order to do this (Scottish Government 2008). A key shift in this regard has been the recent announcement to integrate community health and social care services under Health and Social Care Partnerships (see Integration of Adult Health and Social Care Integration Bill, Scottish Government 2012b).25

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25 The scope of services offered under such partnerships is vast and includes Respite Services, Adult Social Work Teams, Mental Health Officer Services, Day Care, Community Mental Health Teams, Housing Support, Community Development and Support Work (Mead 2012)
In both countries, professionals who belong within multi-disciplinary teams (e.g. Community Mental Health Teams (Highland) and Care Centre Teams (Canada)) are required to collaborate and work together in order to ensure that service users are given the necessary support to remain within communities that are familiar to them. From the wider literature, a key issue in relation to collaborative team working centres around the blurring of boundaries in terms of roles and responsibilities (Sainsbury Centre for Mental Health 1997; Onyett et al., 1997; Rees et al., 2004). In the modern community health landscape, therefore, traditional frameworks involving clearly defined roles for practitioners have been replaced by increasingly flexible and blurred boundaries as part of the community care agenda (Williams et al., 1999).

However, collaborative team based working can present challenges, particularly around power sharing, knowledge and control (Bourke et al., 2004). It can also lead to a lack of support from management and increased administrative workload (Parry-Jones et al., 1998). Nevertheless, as the data above highlights, being part of a team can encourage better patient-centred care and can foster a mutually respectful and supportive environment (Bourke et al., 2004): ‘we're not precious within the team’ (OT Highland).

Moreover, professionals from this study noted the way in which providing care to dispersed populations was challenging in terms of workload and professional isolation; belonging within a team can therefore protect against such factors. Indeed, the current study evidences positive collaborative working between rural professionals who belong within community mental health teams. In particular, it was noted the way in which information sharing was important for team building and a sense of cohesion:

‘if there’s something that, training wise or otherwise, that has come up, we’re all telling each other……and whilst because of my physical limitations, I might not be able to go, my colleagues might and they’ll be able to feed it back’ (OT, Highland).

Sharing information was also considered important due to the time constraints that some professionals were working under:

‘CTO [Compulsory Treatment Order] applications need to get to the Tribunal within 28 days, so you’re working within pretty tight timescales […] consequently, you have to have good working relationships with people’ (MHO, Highland).

Whilst such factors can arguably be found in both urban and rural contexts, there was a general feeling from the current study that the blurring of boundaries, which sometimes required professionals to operate outside of their area of expertise, was due to the
constraints of practicing in a rural area; in other words, if they could not do it, there was nobody else that could:

‘there is good collaborative working, probably because there has to be’ (MHO, Highland).

In contrast to arguments that it can lead to a loss of efficiency (Sayce et al., 1991) the current findings highlight the way in which colleagues and resources are pooled together to ensure rural service users are adequately cared for.

A previous comment by a Voluntary Organisation Manager (see comment on p. 173) centred on the challenge of collaborative working due to theoretical differences. This is an important point because if the focus in health policy is on collaboration (Larkin et al., 2012), then there needs to be on-going recognition of such a fundamental issue. For community mental health teams this can be particularly challenging given that professionals from different fields are required to work together within one team. As Singh (2000) notes:

‘Advocacy of a single paradigm/approach and ideological commitments to particular models of care can lead to rigid views and responses from team members. Debates and differences about care and control, civil liberties and health, biology and psychosocial influences, medication and psychotherapy etc., although reflecting differences in training and personal opinion, may also become implements of inter-personal battles in fragmented and conflict-ridden teams’ (p. 416).

However, responses from interviews with professionals in the current study suggest that bringing these theoretical frameworks together within a team is less challenging in rural areas:

‘in rural areas, I think our roles probably merge much better and blur much better’ (OT, Highland).

Implicit within this is the understanding that professionals have to communicate and get along due to limited options:

‘there’s nobody else to do it’ (OT, Highland).
In some instances such limited options required innovative thinking and crossing boundaries (Bourke et al., 2010):

‘our Housing Officer does a fantastic job and he doubles up sometimes if we need to go into someone’s house that requires two workers [CPNs], and not a female alone…then he comes in’ (CPN, Highland).

5.5 Theme 4: Service Resources

A further theme from the interviews with service providers centred on service resources. Due to the current economic downturn, some professionals in Highland felt that teams were generally acting in a 'protectionist' manner and, therefore, only taking cases that were high priority. As a result, waiting lists in some areas were exceptionally long:

‘[in terms of resources, we have to ask] ‘is this okay for the team to take on….does this fit with what our job is and what it’s supposed to be’…..and in the middle of it all is the client, and it is quite awful sometimes when you have to say that it’s not right for us to be involved. That might mean that someone is kept waiting for a long time’ (CPN, Highland).

In Highland, professionals felt that the cutback of jobs and increasing job insecurity had had direct consequences for both service providers and service users:

‘there’s just a lack of people in post […] there seems to be a particular lack of Social Workers and Mental Health Officers […] it makes it difficult because when my staff are looking for support with somebody, at the moment if they go to someone who is a designated Social Worker or Mental Health Officer, who knows that person and knows their background, it’s much easier…than someone who doesn’t know, and hasn’t had that contact with the person’ (Voluntary Organisation Manager, Highland).

In some instances, interviewees reported that cutbacks had meant workers had less time to spend with clients (see Chapter 6). To address the issue of over-stretched resources, a number of beds in community hospitals had been reduced (for people with dementia), and some daycentres had reduced the days available for service users. It was noted that increased contracting to the private sector had resulted in fewer carers employed within the social work service and, consequently, fewer people (with dementia) being discharged from hospital:
‘What’s happening now, I’m going in and recommending [...] that Mrs Smith would need X, Y and Z [...] to enable her to remain safely within her own environment. We would then put that to Social Work [...] and now they are saying, ‘well I’m sorry, we don’t have any home carers’. So, this too is having a knock on effect as to why folk can’t be discharged from hospital’ (OT, Highland).

Additionally, in both Highland and Canada, restructuring of services had left a number of professionals feeling unsupported, particularly in relation to managing caseloads. In Canada, it was also felt that there was a lack of awareness (from urban professionals) around what rural services were available:

‘I found when I was doing [...] research [...] to do with suicide postvention, the health professionals that were working in the hospitals (in Calgary), didn’t seem to know CMHA [Canadian Mental Health Association] existed and had suicide services [...] they [...] hadn’t bothered to get outside of their own workplace to see what other resources were available’ (Counsellor, Alberta).

By implication, more awareness of available rural services by urban professionals could lead to more effective utilisation of resources. Moreover, as one professional in Highland noted, much of the allocation of resources was driven by an economic rationale without considering other important factors:

‘While NHS and Social Work will deny emphatically that it’s not money driven, it is, it’s certainly not needs led and that’s the huge thing that I’ve found in my job…it’s certainly not needs led’ (OT, Highland).

The above quotes highlight the challenging environments in which rural mental health professionals are currently working. Indeed, in Highland, the integration of health and social care had been challenging for some in terms of providing efficient services:

‘Social Work hold the budget for any equipment or adaptations that I might recommend. [...] So, it means that no matter what I do or recommend, I then have to go to the team leader of the Social Work area and say, ‘please can I have that equipment’ or ‘please can I have money for that’ (OT, Highland).

More widely, investment in mental health continues to go down each year, leaving services even more stretched and under-resourced (MIND 2013). The economic recession and on-going economic fragility have also pushed up demand for mental health services (Dunning 2011), compounding an already difficult situation. In Scotland, a
report by NHS Health Scotland (2012) found people living in deprived areas are suffering more mental health problems because of the economic downturn: out of 50 indicators of mental health, 42 indicated a direct link between greater socio-economic disadvantage and a poorer state of mental health. Similarly, in Canada there has also been a struggle to recover from the economic recession (Pasma 2010) which has had a continuing impact on the health of rural dwellers (Ostry 2009). Such factors are important to note because they highlight the way in which mental health professionals, whilst desiring to do more to help those they serve, are increasingly constrained by wider economic forces. The rural dimension has further implications. Changing demographics, such as population decline and an increasingly ageing population, have directly impacted on service provision and have put some communities at risk of becoming ‘fragile’ (Highland Council undated).26 A further point here is the significant use of Emergency Detention Certificates (EDCs), Short-Term Certificates (STCs) and Compulsory Treatment Orders (CTOs) that Highland professionals use in comparison to professionals in other Scottish Health Boards (Mental Welfare Commission Scotland 2012) (please see Chapter 4). Evidence from this study has also found GPs over referring people to Community Mental Health Teams as a ‘fail-safe’ policy because of the limited availability of backup services. The implication here is that, besides its impact on the level of service provision, limited resources can create civil liberties issues due to the numbers of service users who are deprived their liberty without having committed a crime. This could potentially become of greater concern if compulsory admissions in Highland were to continue to rise simply due to on-going cutbacks to resources.

5.6 Theme 5: Role of Voluntary Organisations in Rural Mental Health Service Provision

This final theme explores service provider perceptions on the role of rural voluntary organisations in providing mental health care. As previously mentioned, there is limited knowledge on the nature and scope of the voluntary sector in rural areas (Scottish Council for Voluntary Organisations 2003). Data from this study reveal that they form a key part of rural service provision from the perspective of service providers. Nevertheless, in line with the wider literature, the issue of partnership working (i.e. contracts that are forged between the statutory sector and the voluntary sector) was noted.

26 Based on the Highland Council’s ‘Zones of Fragility’ two of the Highland locations in this study are defined as ‘Most Fragile’
by one Voluntary Organisation Manager to be something that required negotiation, given the differences in framework between the two.

For professionals in both the Highlands and Canada, the voluntary sector was an important part of rural community life:

‘[this] county runs on voluntary groups’ (CPN, Highland).

Many felt that in the current context, voluntary organisations were increasingly relied upon to fill the gap left by other services:

‘I think it’s always been the case here that the ‘not for profits’ have filled the gaps that have been left’ (Counsellor, Alberta).

‘[in rural areas] you have agencies like Alzheimer’s Scotland and Chest, Heart and Stroke […] more and more we’re needing it because the funding just isn’t there’ (OT, Highland).

However, there was increased competition for funding between voluntary organisations due to the current economic climate:

‘I think we’re all aware of the climate and cutbacks, and looking for other ways to expand. I mean we talk about that at our management meetings […] what we’re going to do in the future’ (Voluntary Organisation Manager, Highland).

Others discussed the issue that voluntary organisations have been affected badly by the recession of 2008 (National Council for Voluntary Organisations 2012) whilst at the same time struggling to deal with the demand for their service due to it\textsuperscript{27}, adding further pressure on them:

‘I think more and more [rural voluntary organisations] are needing to serve a lot more people and so they need more resources’ (Counsellor, Alberta).

It was noted that much of the funding for voluntary organisations came from the statutory sector. However, such a reliance on one source for funding had not only compromised their independence in terms of their lobbying and campaigning power, but also in their ability to be creative in how they deliver their service (see section 2.6.2):

\textsuperscript{27} Calls related to employment and financial concerns to MIND have doubled since 2008 with 40% going unanswered due to the surge in demand (BBC 2012)
‘voluntary organisations used to have a lot more ability to be creative and go off and do things differently, their funding now is so closely attached to the Local Authority […] that they have less independence and I think that’s a bad thing […] If you become dependent solely on the Local Authority to be your funder, you do what the Local Authority asks you to do […] you’re not going to be more critical of the people who give you your money’ (MHO, Highland).

For one manager of a voluntary organisation (Highland) partnership working with the statutory sector was about negotiation:

‘Yes, I think it’s the same with any changes isn’t it…and changes with contracts…you have to discuss it and work things out’ (Voluntary Organisation Manager, Highland).

However, in contrast, one Canadian professional felt that partnership working involved the government simply offering guidelines and setting boundaries in order to help the organisations achieve their aims:

‘I’ve worked for lots of non-profit agencies and the government wasn’t actually so intrusive, like they do have some guidelines but nothing that affected the integrity of the organisation. It was more helping non-profits fly straight […] it was just ‘here’s the boundaries within which you can operate’ (Psychologist, Alberta).

Given the limited employment opportunities in rural areas, it was felt that voluntary organisations were key in providing opportunities to local people. Lower staff turnover was found to be beneficial as it allowed the staff to forge strong, lasting relationships with service users:

‘there is less turnover of staff in the voluntary sector in rural areas. As a result, you sustain relationships with people for longer and you’re prepared to invest in them because you’re going to sustain them for longer as well’ (MHO, Highland).

The manager of one voluntary organisation felt that the voluntary sector generally encouraged the policy of social inclusion to a greater degree than statutory services. A key contribution of their service was the practical ways people could become independent, whilst at the same time remaining focused on their recovery:
‘in my experience, simple things like people going to clinics or going shopping, we would always try and support the person to go by public transport […] whereas statutory services seem to take people in cars. I think we always try to include people as anybody else would, using the same kind of facilities and resources […] trying to include people in their communities. So maybe it comes down to values and beliefs’ (Voluntary Organisation Manager, Highland).

Given the current landscape, the views on the voluntary sector are important to note. As previously mentioned, on-going issues with the economy have meant the cutback of services and an increasing reliance on the voluntary sector to fill the gap left by formal services. A further issue here is that employment insecurity and financial concerns have increased the number of people seeking help from charities.

5.7 Conclusions

This chapter aimed to discuss the similarities and differences between the experiences of service providers in Highland, Scotland, and Alberta, Canada. The data revealed that delivering mental health services in rural areas can be challenging for a number of reasons. Much of what professionals noted in the current study resonates with the wider literature on rural health professionals; most notably around the themes of recruitment and retention; resource allocation; logistics and collaborative working. Rural service providers in both Highland and Alberta, for example, were limited in terms of opportunities for training or drawing on professional expertise. The increasing use of technology in Canada mitigated this to some extent. As previously noted, the Highland region has a considerable number of learning centres that are operated through the local university (UHI). The implication here then is that it is not a lack of technological resources, so much as a lack of imagination and innovatory thinking around how to support remote and rural professionals.

Being known in the community as a mental health professional meant the separation between public and private life was difficult to achieve. Professionals in both countries noted the ways in which rural practice can be challenging, requiring them to adopt innovative thinking in response to localised problems. Such innovative thinking is made possible by strong collaborative relationships that are achieved between rural service providers. Such issues suggest rural practice brings with it distinct challenges that are unique in comparison to urban practice. By inference, it also suggests that it can deter
others from coming to work in rural areas. (Certainly this was perceived to be the case by some interviewees).

In terms of cross-national comparisons, data in this chapter reveals a number of points of similarity and divergence between the experiences of mental health professionals in both countries. Divergence, for example, was seen in relation to rural service design with Canadian professionals generally feeling that services were designed in a way that accommodated rural factors such as time and distance. In contrast, Highland professionals felt length of time for travelling to dispersed populations, and the implications for how many clients could be seen in one day, was not clearly grasped by service planners. Moreover, it was noted that there was not a good distribution of services in Highland, with most located centrally in Inverness.

In Canada there were considerable challenges in terms of access to psychiatry, resulting in service delivery gaps and the data highlighted on-going issues in terms of delivering services to First Nations people. Whilst this was partly related by the interviewees to a lack of joined-up working, the data highlighted that it was also about service provider perceptions and a culture of fear in terms of delivering services on reserves.

Whilst the current economic downturn had impacted in a variety of ways for professionals in both countries, in Highland constraints around resources were particularly pronounced. For Highland professionals, this was evident in terms of their discussions of only taking cases that were high priority. The impact of this was that low priority service users were being left for longer without being helped. It is unclear what the long-term impact of this will be, however, in economic terms service input for an acute individual is likely to be considerably higher than lower-level preventative care. Additionally, for those service users who are acutely unwell, the considerable use of compulsory admissions by professionals in Highland is important to note. Arguably this is due to limited resources and backup services but it has significant implications for civil liberties and, therefore, should not be taken lightly. For service providers in both countries, the role of the voluntary sector was seen as an increasingly important aspect to rural mental health service provision (in terms of lower-level interventions), given the current economic climate.

This chapter has, therefore, answered research question five ‘What are the challenges that service providers face in rural areas?’ and shown that rural practice brings with it distinct challenges in comparison to urban practice. In terms of cross-national differences, the
data show that rural service design is more accurately aligned to the needs of rural health professionals in Canada compared to Highland. Despite increasing resource constraints faced by providers in both contexts, this was acutely felt by Highland professionals resulting in longer waiting times for service users. The challenges of delivering to remote and rural service users is seen to be lessened by strong collaborative working between professionals and a willingness to work below grade in order to get things done.

Evidence from professionals in both countries suggests that the voluntary sector is perceived to play a vital role in filling the gap left by formal services. Chapters Six and Seven of this thesis explore the contribution of the voluntary sector further, demonstrating the vital contribution such organisations make to the recovery process for service users and also in terms of strengthening local social capital. Such findings thereby compliment and add weight to the evidence presented here.

In briefly summarising the similarities and differences in both contexts the following was noted:

- Canadian professionals felt that the provincial government designed services in a way that accommodated rural factors, whilst Highland professionals felt that rural areas were generally seen as less of a priority for policy makers.

- There remain considerable challenges delivering services to First Nations people in Canada and these constitute a special case.

- There were similar challenges in both contexts in terms of the overlap between the private and public domain that comes with living and working in rural areas.

- Professionals in both countries faced similar challenges in terms of professional isolation and lack of opportunities for professional development.

- Opportunities for professional development were increasingly restricted due to the current economic climate. For Highland professionals, training opportunities were generally offered around the central belt of Scotland, creating further restrictions.

- There was evidence of positive collaborative working amongst rural professionals in both countries. In both Highland and Alberta, service providers placed value on the importance of forging links with others as a way to develop good quality mental health services in spite of increasing cutbacks.
Restructuring of services had left professionals in both countries feeling unsupported. However, this was acutely felt by Highland professionals as it was linked with cutbacks and decreased resources (resulting in longer waiting times for service users). Limited resources in Highland was also linked with GPs over referring to mental health services.

Professionals in both countries felt that the voluntary sector was an essential aspect in the delivery of mental health care in rural areas, given the limited options.
CHAPTER 6

THE ROLE OF RURAL MENTAL HEALTH VOLUNTARY ORGANISATIONS: FACILITATING RECOVERY
6.1 Introduction: How rural voluntary organisations promote recovery

The idea of building sustainable communities at the local level within current policy discourse (i.e. ‘Big Society’ Cabinet Office 2010) has meant an increasing interest with all things local. As previously highlighted, the voluntary sector plays a key role in local health and social care delivery for rural communities (Dickinson et al., 2012) and yet there is limited knowledge in relation to the rural voluntary sector (SCVO 2003). This chapter focuses on one specific area, the role of rural mental health voluntary groups in order to understand more about their contribution in rural Highland and Canada. The questions under study are ‘What benefits are there for service users attending voluntary groups in remote and rural areas?’ and ‘Do voluntary groups offer something that other rural mental health services do not?’

Analysis of the data revealed a number of emergent themes such as meaningful engagement, hope, gaining control, peer support and reclaiming a sense of self that were central in terms of what rural voluntary groups have to offer members. Such themes are core tenets within the recovery paradigm which is, therefore, used to interpret the data. As highlighted by the wider literature (see Chapter 2), recovery invokes elements such as hope and healing, personhood and the right to a valuable and meaningful life for all who experience mental health problems (Anthony 1993; Deegan 1997; Tierney & Kane 2011). Its holistic approach to care encourages both service users and service providers to see beyond the diagnostic label, broadening an understanding of the person to something more than simply ‘mental patient’. However, as noted in Chapter Two (p. 43), there remain concerns around how to implement recovery-orientated practice based on the current knowledge base (Davidson et al., 2006a). The process of recovery also requires more conceptual clarification (Roe et al., 2007) given that it is intuitive and highly subjective. The following chapter addresses these concerns and provides a critical analysis of the data to identify the ways in which recovery is promoted and facilitated, and what the process entails for members.

The resonance of the themes emerging from the data analysis was revealed as part of that interpretative process. It was not decided before analysis began to use the recovery paradigm as an interpretative framework but the suitability of this was revealed through the close reading and early stages of thematic analysis. In line with the tenets of grounded theory, therefore, the use of the concept of recovery as an interpretative framework emerged from the data analysis process. Key themes and underlying patterns were coded reflecting the ‘meanings and assumptions’ that participants attributed (Miles
& Huberman 1994) to their experience of using rural mental health voluntary organisations.

Part One of the chapter presents three broad themes with associated sub-themes. The first theme concerns the way in which voluntary organisations are conceived as sites that provide opportunities for meaningful engagement for members (Theme 1). Included within this is the idea that attending a voluntary organisation moves beyond simply having somewhere to go through the day, to a site that can allow members to feel engaged and connected. The second section entitled ‘Gaining Control: Recognition of Agency’ (Theme 2) refers to the way in which the voluntary organisations can help members to gain control by encouraging independence through choice and by encouraging coping frameworks: essentially conceiving members as autonomous agents. The third theme is focused on issues relating to relationships both within and outside the voluntary organisations (Theme 3). In terms of the former, trusting and supportive peer relationships were found to be a key benefit for members, whilst the latter focused on the way the voluntary organisations had helped some members to repair old family rifts.

Part Two continues to use recovery as an interpretative framework but does so in terms of how the voluntary organisations are different to other rural mental health services. In the same way as Part One, the second half of the chapter presents a further three themes (Themes 4, 5 and 6) with associated sub-themes. The first theme presents the theme of relational continuity. Within this theme, the data evidence the many benefits of familiarity with staff (Theme 4), including its utility in terms of preventative care and the way in which it can inspire hope for rural members. The second theme ‘Individualised Care’ (Theme 5) refers to the importance of giving time to members, which can encourage positive risk taking. Finally, the last theme in this chapter (Theme 6) centres on the way in which the voluntary groups are responsive to need through structure (i.e. preventing members from slipping into depression or old patterns of behaviour) and availability.

**Part One**

Part One presents data in relation to understanding the benefits of attending rural mental health voluntary organisations for service users (research question 2) and will use the concept of recovery to interpret the focus group findings.

**6.2 Theme 1: Meaningful Engagement**
Theme One focuses on the role of voluntary organisations as engaging places for members. It includes three Sub-Themes: 1A) Feeling Accepted; 1B) Meaningful Activity; and 1C) Motivation which are all things participants feel/receive from attendance.

As the wider literature demonstrates, living in a rural area can be challenging for those with mental health problems due to the lack of mental health facilities and also limited professional input. Attending a mental health voluntary group, therefore, may allow members to connect with likeminded people, which in turn can help them to construct a positive identity that is valued and accepted. As the sub-themes within this section demonstrate, voluntary organisations are often important for the recovery process by the way in which they provide meaning for members. This chapter, therefore, demonstrates that attending a voluntary organisation is about more than a place to go through the day, such groups provide places for meaningful engagement by the way they encourage members to feel accepted, by the range of activities they provide and by the way they can motivate members in a variety of ways, from stopping them slipping into depression, to encouraging them to venture into the community to raise awareness about mental health support.

6.2.1 Sub-Theme 1A: Feeling Accepted

The first sub-theme presented here relates to feeling accepted. Overwhelmingly, participants reiterated many times throughout the focus group discussions, the importance of finally finding a place where they felt accepted for who they were, regardless of having a mental health problem. For many participants, experiences of stigma and discrimination had made it extremely difficult for them to feel accepted by other people that they encountered.

An important benefit from attending a voluntary group was that it offered service users a place where they felt accepted and respected because all members understood what it means to experience a mental health problem. Given the problems of stigma and social exclusion that many participants reported (see Chapter 4), going to a place where they felt completely accepted was extremely important and noted by participants in all of the focus groups:

‘That is exactly what this place has given us…..it’s given us the ability to be ourselves’ (Male, Northern Alberta).
‘mutual understanding and respect which, I’m not saying we don’t feel that from a professional standpoint, but you absolutely feel that here’ (Female, Lower Highland).

Unconditional positive regard, therefore, allowed service users to just be themselves:

‘I think that is one of the benefits of coming here…..no one judges no one here…and when I’m here, it feels like I can forget all about the worries and troubles’ (Male, Northern Alberta).

For many, this had been difficult to achieve in mainstream society, where people, including family members, had often avoided anything to do with mental illness due to fear of difference:

‘we can be who we are [here] whereas when we’re with family or friends, who don’t understand, who are afraid of mental illness, you have to stifle it’ (Female, Northern Alberta).

In the above quotes, there is a sense that being part of a rural mental health group had allowed members to accept their mental health status, essentially freeing them from the constraints of such a label through ‘mutual understanding and respect’. The idea of acceptance within the process of recovery is an important theme, involving seeing and acknowledging ‘what is’ (Spaniol & Gagne 1997). Given the challenges that many service users face in dealing with their mental illness, acceptance can encourage the individual to accommodate their experiences in order to move on (Repper & Perkins 2003, p. 95) and to replace hopelessness with hope (Deegan 1996):

‘you’re in a group where you’re not trying to hide your mental illness [……] it’s a real relief to be able to say what you want’ (Male, Lower Highland).

Within this process, therefore, the support and acceptance of others is important (Sullivan 1994; Anthony 1993). Being with others who were perceived to be supportive and non-judgemental offered service users a space within which they could begin, not only to feel accepted within the external environment, but also within themselves; thereby helping to ameliorate stigma:

‘since I’ve been here, it just feels like I have more of a sense of friendship, acceptance, security’ (Male, Northern Alberta).
Given the limited mental health support in rural areas, finding places to feel accepted and respected is arguably even more important.

In the above quotes feeling accepted amongst likeminded individuals allowed participants to move beyond their diagnostic label and to be seen by others within the group as an individual with interests and abilities (Brown & Kandirikirira 2007). The recognition that they were valued regardless of ‘the problem’ reduced anxiety and allowed for more natural interactions to occur that negated any fear of reprisal for being ‘different’. Indeed, the importance of feeling accepted as a mechanism to move beyond the ‘patient’ identity cannot be underestimated. As Anthony (1993) notes,

‘Recovery from mental illness involves much more than recovery from the illness itself. People with mental illness may have to recover from the stigma they have incorporated into their very being; from the iatrogenic effects of treatment settings; from lack of recent opportunities for self-determination; from the negative side effects of unemployment; and from crushed dreams’ (p. 527).

Recovery therefore includes recovering from a potentially oppressive social context (Ochocka et al., 2005). As the findings from Chapter Four demonstrate, living in a rural environment as a service user can be particularly challenging; cultural norms that are negative, and sometimes hostile, to mental illness coupled with limited services can mean finding places of acceptance takes on an even greater significance than perhaps for those living in more populated areas. This section, therefore, shows that feeling accepted is a key benefit to attending a rural voluntary organisation and one that links to recovery.

6.2.2 Sub-Theme 1B: Meaningful Activity

During the focus group discussions, participants highlighted the range of activities for members to take part in. For some, these aspects were important to note because it was felt that the rest of the community assumed they just ‘go in here and sit down’ (Male, Northern Highland). As this section outlines, however, on a deeper level such activities allowed members to connect with each other and to feel a sense of achievement. In this way the activities were personally meaningful.

Participants noted that the voluntary groups provided a space within which they could socialise and, in some instances, express different aspects of themselves. Given the rural cultural factors identified in the previous chapter (Chapter 4) this seems a particularly
important factor as an avenue for self-expression and for connecting with others. One participant relayed how she had been inspired to start a library at the organisation, out of her love of books. The library gave her an opportunity to share her interests, or aspects of herself, in a way that was also beneficial to others. Generally responses around the subject suggested that for many participants the activities provided a way for them to connect with others; such activities were therefore meaningful (Malpas & Weekes 2001). Of particular importance in the context of recovery was that members could make the choice themselves whether to take part, or simply observe:

‘I enjoy my games and pottering about [...] I like going in the kitchen and doing the dishes [...] some people like doing the arts and crafts. Everyone is different’ (Male, Northern Highland).

‘My favourite programme is ME [Membership Empowerment] and we talk about boundaries, relationships, gossip, judgement [...] I’ve learnt a lot through it.....then the evening activities I enjoy [too]’ (Male, Southern Alberta).

Within the recovery paradigm, the notion of meaningful engagement is a recurrent theme (Davidson & Strauss 1992; Andresen et al. 2003; Repper & Perkins 2003). In particular, alternative forms of engagement can provide the opportunity to socialise and gain a sense of achievement (Brown & Kandirikirira 2007). In their review of qualitative accounts of recovery, Davidson et al. (2005) found that being involved in meaningful activities and the expansion of valued social roles was a common theme in first-hand accounts of recovery. Particularly relevant to the current study is the idea that it is not so important what activities or roles people choose to become involved in, or to pursue, as much as it is important for them to participate in personally meaningful and gratifying activities. As the first quote above demonstrates, such meaningful activity may simply be ‘pottering about’ or spending time in the kitchen of the voluntary organisation, whilst for others it is about ‘doing the arts and crafts’ (Male, Northern Highland). In the second quote, the participant found that taking part in programmes such as Membership Empowerment (ME) was important for learning about being socially responsible to those around him, essentially affording him a sense of purpose and meaning (Sullivan 1994). In terms of recovery, such activities also encourage an exploration of identities that move beyond that of mental patient (Onken et al., 2002; Davidson et al., 2005).

Meaningful activities can also be important by giving a sense of achievement related to notions of contributing to the wider community (Davidson et al., 2005). For example,
some participants were part of a voluntary organisation which produced a newsletter. The newsletter included such things as articles on different diagnoses and personal stories from members. Via the newsletter, participants were encouraged to share their stories, or anything else they felt may be of interest to other members, again offering them an opportunity to express themselves. In this way it allowed members to experience giving as well as receiving (Slade 2009a):

‘I’m one of the members that’s involved with the newsletter [….] I find it quite challenging because I don’t get to work on a computer all of the time [….] There’s all sorts of things we put in it… I put in what I did with Ethnic Day this year… I also did something on food in the province where I grew up [….] I was able to tell a few things about myself […] then at the end of the month, we put everything together and just wrote it up’ (Female, Northern Alberta).

In this quote there is a sense that the participant was not only able to take part in something meaningful but also in something challenging; so it was empowering (Schrank & Slade 2007). A further dimension is that the participant’s contribution reflected autobiographical aspects of herself that were unrelated to mental illness. Such activities essentially reinforce recovery in that the person is seen beyond the limits of disability, as someone with abilities, possibilities and interests. Participants also noted that their newsletter was shared internationally. Taking part in this way, therefore, allowed members to feel that they were making a valuable contribution within their own mental health community (at a local level) and to the wider international community.

Furthermore, such creative forms of engagement (i.e. writing personal stories) can be an important aspect of recovery in that it provides opportunities for reflecting on the life journey (Wallcraft 2003) in order to understand and grow from experience. Indeed, unlike the psychiatric history and its associated story of illness, the personal life story is meaningful and can enable someone to move beyond what has happened in order to rebuild a sense of self (Repper & Perkins 2003, p. 105); it can allow a point of reference for the person to see where they have been and where they are now. Such a narrative can also provide context and purpose for the future, it can be ‘the spring-board for hope’ (Slade 2009a, p. 42). Interestingly, it was through the personal accounts of mental illness that the momentum for recovery initially found its roots; such narratives provided ecologically valid points to what recovery looked and felt like from the inside (Slade 2009a), allowing for an increased understanding about the lived experience of mental illness from those affected by it.
This section has therefore shown that the activities provided by the voluntary organisations are a key benefit for members because they provide avenues for self-expression and they also allow members to connect with each other.

6.2.3 Sub-Theme 1C: Motivation

The idea that service users are accepted and respected also contributed to their level of motivation to connect with others. Responses around this suggested that knowing there was a familiar group to attend provided hope and encouraged service users to get out of bed. Given the potential for social isolation in rural areas, this takes on a further dimension in terms of its importance. Some participants felt that maintaining contact with the group was paramount in stopping them from slipping back into depression (Malpas & Weekes 2001):

‘I think for a person that’s in depression, if they’ve got a place to go, they’ll get into the tub and shower….it’s amazing what that does for a person….put on clean clothes and get out there…..and that really boosts them’ (Male, Northern Alberta).

It was important for many in terms of their wellbeing to continue to connect with others, even for short periods of time:

‘being here gives me the security and the willingness to not give up in life….not let my emotional troubles take over that make me want to quit’ (Male, Northern Alberta).

‘you can sit at home in a rut if you want to, you know, you can either make the day good or bad, it’s up to yourself’ (Male, Northern Highland).

These comments convey a sense of hope as a cause for motivation and adjustment (Larsen & Stege 2012). The belief that there was a reason to keep going, to avoid lying in bed, or ‘giving up’ (i.e. lack of interest) resonates with Miller & Powers (1988): ‘[hope is] an anticipation of a future which is good, based on mutuality, a sense of personal competence, coping ability, psychological well-being, purpose and meaning in life, a sense of the possible’ (p. 8). In the above quotes, attending the voluntary organisations facilitated this process and contributed to a healthier outlook (‘you can make the day good or bad’) and consequently healthier behaviours (i.e. connecting with others). Indeed, the following extract demonstrates the nature of the challenge for participants in overcoming the sometimes debilitating effects of mental illness:
Male 1:  *From knowing what my dad went through... I literally had to get him out of bed...and throw him out the door...to get him to go places....and then I made him promise me that every day he would go out and do something*

Researcher:  *And then after attending (to Male 2) were you quite motivated to get out of your bed and come here?*

Male 2:  *Yes, well said*

This dialogue provides some understanding to the way in which even the ordinary things of everyday life can seem impossibly difficult as a result of having mental health problems. The idea of venturing from the safety of a personal refuge can be a monumental act for those who feel vulnerable and rejected (Malpas & Weekes 2001). Such sentiments are echoed by other first-hand accounts of mental illness by service users (Deegan 1988; Boevink 2012). These articulations again point to the considerable difference that the voluntary groups can make to a person’s recovery; they increase the level of motivation that members have by encouraging involvement and belonging. Indeed, venturing out in rural areas and connecting with others has significant implications given the high visibility of those with a service user status noted in Chapter Four.

The data also revealed that for some participants motivation was directly linked to the feeling of having a purpose:

‘*I think the change comes from people coming together to make a difference*’ (Female, Lower Highland).

‘*I think [the organisation] is very important in people’s individual recovery. We’ve had people who have been house bound because of their problems but the attraction of going to something to do with [the organisation] has lured them out*’ (Male, Lower Highland).

The implications from the above comments move beyond simply being a member of a mental health group towards having a challenging goal or purpose; essentially motivating members due to the empowered identity it generated. This kind of purposeful outlook is supported by the number of service-user led projects and initiatives that have taken ground in the mental health landscape (Tait & Lester 2005). In the context of recovery,
such involvement (i.e. bringing service users together for a purpose) has been integral to its growth (e.g. Hearing Voices Network and Working to Recovery). Coming together with a purpose was, therefore, an important mechanism for improving recovery outcomes for members (Faulkner & Kalathil 2012).

In their study on service user drop-ins, Malpas and Weekes (2001) found that motivation was one of the most important benefits of using a drop-in for participants. Not only was motivation found to help with recovery, it also encouraged members to venture into the community. In line with this, a number of participants in this study talked of the way in which they had been inspired to reach out to others in the community:

‘if I see someone that’s struggling [...] and I think they can benefit from this programme, then [...] I will suggest it to them…to come here and check it out’ (Female, Northern Alberta).

Whilst this was beneficial in terms of raising awareness, within a rural context, with limited service provision, such reaching out becomes even more important. This was highlighted by one participant of First Nations descent (Canada) who actively sought to raise awareness about the voluntary organisation amongst First Nations people on a nearby reserve:

‘I am a First Nations person, just south of here […] they have Community Mental Health Services and a Woman’s Shelter….and I am always giving out pamphlets because they don’t have a [group] like we do here’ (Female, Northern Alberta). (The issue of service provision and First Nations people was discussed in Chapter 5).

However, the data also revealed that for some participants, attending the drop-in had implications in terms of remaining well (Burns et al., 2002a, p. 15):

‘There is a tendency to use drop in centres over a long period and become stuck in them’ (Male, Northern Highland).

The above quote raises an important issue around using mental health groups long term i.e. they could inadvertently reinforce a diagnosis rather than helping people to transcend it. Furthermore, given the isolation of rural life (i.e. limited avenues for creative social participation), it could be argued that subscribing to a ‘mental illness’ label may be due to a lack of alternatives. In this way, their situation might conceivably be forced upon them due the rural context rather than by the logic of their psychological state. It is unclear how long members had been using the organisations for, some participant responses
suggested many years, however overwhelmingly the responses indicated that the organisations formed a key aspect of their mental health experience in ways that were essentially positive.

Nevertheless, voluntary organisations may not always get it right and there can be dramatic failures. One clear example in this study was highlighted in Canada when participants described a recent event where a member of the organisation (service user) had murdered a member of staff. The point here is not to apportion blame, such events are invariably about a combination of factors, however, it serves as a reminder of the importance of joined-up working in rural areas in order to provide a more coherent approach to care (i.e. voluntary organisations should not be viewed as a panacea for the lack of rural service provision elsewhere). In the current economic climate with on-going cutbacks to public health services and an increasing reliance on the voluntary sector, such joined-up working is arguably even more relevant.

6.3 Theme 2: Gaining Control: Recognition of Agency

The recognition of agency is the second key way in which rural voluntary organisations promote recovery. This theme focuses on the ways in which the voluntary groups can help members to gain control of their lives. The impact of mental illness can often leave the individual vulnerable, confused and with a sense of helplessness (Deegan 1988; 2002). In particular, any sense of self can be diminished, or indeed subsumed within an ‘illness’ identity. As the wider literature notes, gaining control is a central tenet of recovery (Anthony 1993; Smith 2000; Ramon et al., 2009). Being able to gain control can encourage service users to take greater personal responsibility, essentially allowing them to heal and grow beyond the diagnostic label. The sub-themes within this section are as follows: 2A) Promoting Independence; and 2B) Encouraging Coping Frameworks.

6.3.1 Sub-Theme 2A: Promoting Independence through Choice

The data demonstrates that the voluntary groups helped service users to gain control of their lives. Of particular importance was the way in which the organisations sought to promote personal autonomy, independence and personal decision making, which encouraged an active sense of control for members and a belief in the efficacy of their judgment and actions:

‘this [organisation] has made people realise that within themselves, they have the power [...] and then they [just] need confidence building’ (Male, Northern Alberta).
‘that’s one of the awesome things about this place…[the staff] are not here to be babysitters…if we’re capable of doing things on our own, we’re expected to do it’ (Female, Southern Alberta).

‘[attending here is empowering] instead of someone dictating to you what you can and can’t do, and kind of patronising you as well’ (Male, Western Highland).

Having choice and the freedom of whether, and how, to participate in programs/activities was an important aspect that promoted self-determination and personal responsibility (Onken et al., 2002):

‘I think the beautiful thing about it, is that we choose what we want to participate in’ (Female, Southern Alberta).

‘if you want to be on your own you can just come into this room and be left on your own and you can go to sleep in here, or you can go and play pool or go on the laptops’ (Female, Western Highland).

Such responses illustrate the way in which the recognition of agency allowed members to move beyond the passive ‘recipient of care’ label and embrace a more engaged and active identity:

‘We’re participating in our own wellbeing and that we didn’t get anywhere else……by coming to this group, they allow us a say in our own wellbeing’ (Male, Northern Alberta).

Indeed, there is a sense that participants’ journeys towards a more empowered identity fundamentally required a recognition of agency by others (i.e. staff) in order to establish this sense of selfhood. This process often involved time and patience:

‘A clinical relationship with a psychologist or doctor […] they will listen to you but they’ll push you to establish the next point……whereas the difference here is, they don’t judge you, they don’t push you to develop or go to the next point, they’re patient enough to wait for you to realise what the next point is on your own’ (Male, Northern Alberta).

In this way, choice-making skills were achieved by encouraging members to master skills a little at a time (Onken et al., 2002). Moreover, the idea of not being judged, of not being pushed ‘to the next point’ suggests that staff position themselves in a supportive
role rather than as knowledgeable experts, offering support whilst at the same time valuing the service user as an ‘expert-by-experience’ (Roberts & Wolfson 2004).

The impact of interpersonal processes as a way to help service users gain control cannot be underestimated: if a person with mental health problems is continually treated as ‘sick’ they are more likely to identify with that than if they are afforded respect for strengths and talents (Davidson et al. 2005). In the context of rurality, it is arguable that high levels of stigma and being known in the local community as a service user can reinforce an inferior and negative message to those with a mental health status, essentially diminishing their opportunities for feeling in control. In the current study, the data show that this can simply be about entrusting members to make decisions based on what they want. For example, participants spoke of the positive benefits of using the service as and when they wished, again encouraging greater confidence in their own ability to make decisions around what was right for them. Consequently, actions flowing from this empowered position were associated with good mental health and preventative strategies, by knowing when to use the service and when not to:

‘Many mornings I’ve got up, looked out the window and thought, ‘no’ […] but then knowing I’ve had this place to come to’ (Male, Northern Highland).

‘I think the fact that we use the [organisation] when it suits us…. I’ve been in all kinds of outpatient programmes….but this is less structured, less rigid, we have more say in what we do […] I don’t feel I have to come here’ (Female, Southern Alberta).

There is a sense from these comments that being given the opportunity to regain a sense of agency and efficacy helped participants to feel in control of both their mental health and their life more generally (Andresen et al., 2003) which helped to ameliorate feelings of helplessness (‘I don’t feel like I have to come here’).

As previously noted (p. 43) recovery has not been welcomed in all corners. In particular, there is concern that its promotion of personal responsibility and self-management may be used to justify the cutback of services (Joint Position Paper 08 2007). Its preoccupation with individual choice also tends to ignore the structural factors that restrict and exclude service users (Weisser et al., 2011) in a similar way to the policy of social inclusion. Such concerns are valid. In the current policy context, massive spending cuts to social welfare services have indeed bolstered discourses which individualize mental health problems such as ‘patient-centred management’ and ‘self-management’ (Morrow 2011) within a neo-liberal agenda; essentially putting
responsibility with the individual to get better. The findings from Chapter Four, however, clearly demonstrate an on-going need to remain vigilant to the structural barriers that serve to marginalise people with mental health problems (through factors such as stigma and discrimination). In terms of promoting independence and personal responsibility, data from the current study suggests this is not about doing everything alone. It is about encouraging service users to frame the experience so that it becomes one of life’s challenges, essentially allowing the ability to self-manage to develop. This transition involves encouraging members to be responsible for their wellbeing, including seeking help and support from others (Slade 2009b) which creates a more empowered identity. This should not involve cutting back services, or even being quick to remove someone from services if they demonstrate positive outcomes in relation to recovery. It is essentially about the careful and efficient allocation of resources that are responsive to the process and that enable choice.

Facilitating choice is one of the major goals of recovery (Kravetz & Hasson-Ohayon 2012). As previously noted (see Table 1, Chapter 2), the approach of the mental health system has traditionally been one of compliance in relation to the service user, involving the loss of free will and personal responsibility,

‘a finding of mental illness, which is often a judicial, as well as a medical, determination frequently results in a loss of liberty. People labelled mentally ill are usually presumed to be incapable of exercising decision-making power in their own best interests…People who are labelled mentally ill become part of a system that deprives them of control over their life as part of their treatment’ (Chamberlin 1977, cited by Repper & Perkins 2003, p. 26).

In contrast, the principles of recovery establish the right for service users to exercise choice, not only in what treatment should look like but in the very approach to life. Anthony’s (1993) widely cited definition (see p. 44) highlights the profound implications for the shift to recovery. It involves a fundamental change in emphasis; the right for service users to find meaning and purpose in life, or to change attitudes, implies that the starting point is the individual as an autonomous being. The recognition of individual agency enables the adoption of positive attitudes and skills that are needed to make choices (Sugarman et al., 2010). As the participant above noted, ‘We’re participating in our own wellbeing and that we didn’t get anywhere else’ (Male, Northern Alberta). This
process in turn facilitates empowerment by encouraging personal ownership for decisions that members make. Whilst having a sense of agency may be fundamental to the process of recovery, the quality of the experience is a key component in its success (Shepherd et al., 2008). As the data show, this can often be about time and patience to allow members to arrive at the next ‘point’ themselves, ‘they don’t push you to […] the next point, they’re patient enough to wait for you to realise what the next point is on your own’ (Male, Northern Alberta).

The importance of encouraging autonomous decision-making, of conceiving members as experts in their own mental health, taps into a deeper theme around power sharing and the role of subjective knowledge (see Chapter Three). In terms of the current study, voluntary organisations give primacy to experiential knowledge, to the lived experience of members (ideographic). In this way, value is given to individual perspective and to personal fulfilment. Members are also encouraged to tap into their own inner resources thereby helping to facilitate growth, both in their outlook and in their abilities. This is not to suggest that the organisations reject clinical knowledge and expertise; in contrast, they maintain good links with community mental health teams and often accompany members to consultations in order to provide additional information to clinicians. However, the starting point in their approach to care is the inner subjective world of experience and what that means for each member. The essential message for members is that they all have something valuable to contribute. For rural service users who have often been marginalised and stigmatised, this seems crucially important.

6.3.2 Sub-Theme 2B: Encouraging Coping Frameworks

This sub-theme emphasises the way members were encouraged to deal with problems they face on a personal level. By encouraging coping frameworks, participants developed effective strategies to avoid undue stress or worsening symptoms. For some participants, such frameworks focused on the bigger picture, and dealing with life generally, whilst for others, coping frameworks centred on dealing with specific problems. In both scenarios the voluntary organisations facilitated and encouraged this process:

‘when I was younger, I had a lot of anger […] because of this place […] I’m just trying to take it one day at a time’ (Male, Northern Alberta).
For this participant, developing coping frameworks were about ‘taking one day at a time’ so as not to be engulfed by his perceived problems.

‘There was a former staff member […] she always knew when I was depressed…..and on a downward spiral, she would call me and say ‘you get in the shower, get dressed and come down here’…..and I would. So now, I have learned that when I feel like that…like I’m on a downward spiral, I get up, take a shower and I come down here’ (Female, Northern Alberta).

Coping frameworks in the above comment related to recognising the triggers for depression to ensure that she mobilised her internal resources to lessen the impact.

‘Every day is a learning experience in here because different people have different problems, and you really get to learn those problems, and you get to know so that if it ever happens to you, you are ready for it’ (Male, Northern Alberta).

In this quote, developing coping frameworks is shown to be about feeling informed of different diagnoses in order to respond appropriately should he develop those symptoms. These comments show that taking back control involved learning what helped and what did not help, along with how best to protect himself from things that made the problem worse (Repper & Perkins 2003). As the above quotes demonstrate this is highly individualistic.

In line with recovery principles of partnership working (Shepherd et al., 2008), there is also a sense that staff recognise members’ existing coping strategies and, therefore, work with members to develop these further in order to manage the ups and downs of life (Perkins 2007):

‘I tend to see things in black and white…and [the manager will] help me to see the grey areas’ (Female, Southern Alberta).

‘I always wake up and try to be at work half an hour early and I’m always worried the night before […] and then the staff [here], they’ll say, ‘well why worry, you can’t change nothing’…..and so I’m learning not to do that as much’ (Male, Southern Alberta).

In both of these examples members are encouraged to explore their beliefs in order to consider new ways of responding to potentially stressful situations. In the second comment this was directly related to reducing anxiety and consequent hyper-vigilance.
By gaining control over how he managed stress (i.e. learning not to be consumed with worry) it allowed the participant to increase his sense of self-control and to be more confident of dealing with other aspects of his life (Shepherd et al., 2008).

6.3.3 The Self

The above themes of promoting independence (2A) and encouraging coping frameworks (2B) are mechanisms by which service users are encouraged to connect with their own sense of self. The notion of having a sense of self is particularly important in the context of recovery, as it can often be disrupted by the onset of mental illness. It can replace any prior, enduring sense of self, with one that is devalued and dysfunctional (Repper & Perkins 2003), leaving the individual identifying more with the diagnosis than any previous sense of self (Estroff 1989). In addition, a compromised belief of self can potentially leave the individual feeling powerless and with a lack of motivation for personal growth (Ochacka et al., 2005).

In contemporary Western psychiatry, concepts such as personhood or self have generally been ignored in favour of biological approaches to mental illness (Cook 2012). However, in examining the role of self for those with severe mental illness, Davidson and Strauss (1992) identify the ways in which it may provide an essential aspect of improvement in severe mental illness. The authors highlight four aspects of the recovery process which involve the rediscovery, reconstruction and utilization of a functional sense of self. The four aspects are:

1. discovering the possibility of possessing a more active sense of self
2. taking stock of the strengths and weaknesses of this self and assessing possibilities for change
3. putting into action some aspects of the self and integrating the results of these actions as reflecting one’s actual capabilities
4. using an enhanced sense of self to provide some degree of refuge from one’s illness and the detrimental elements of one’s social milieu and to provide a resource with which to battle them (p. 134)

Data from the current study suggest that voluntary organisations facilitate these aspects in a number of ways. For example, in terms of the discovery of a more active self, choosing to use the voluntary organisation often came at a time of crisis for the service user, when they were experiencing despair and isolation:
‘I had been slashing and drinking a lot, and I had made a plan [to commit suicide] and I just happened to stop by here’ (Female, Northern Alberta).

Despite such difficult circumstances, participants implied an awareness of something deeper that helped to guide them to avenues of help that were conducive to their needs. Whilst the voluntary organisations were not responsible for this part of the discovery of self, it seems that after becoming members, the dawning of awareness of an additional aspect of self (one not identified with illness) came through sharing their stories with others that allowed for a point of reference from which to understand their own experiences, ‘[you realise] everyone here has their own story’ (Male, Northern Alberta).

In addition, such interactions allowed for a gradual acceptance of their mental health status and an increasing recognition of their potential as active agents.

According to Davidson and Strauss (1992), once hope for a more active and efficacious sense of self has been established, it results in an internal reflective process, one that involves taking stock of the self in order to understand its attributes and capabilities. It appears that this can happen in various ways in relation to the voluntary groups. For some, the initial intensity of using the group all day every day was found to lessen with the gradual realisation that such an intense engagement was no longer necessary:

‘I use to come down […] before the key was in the door but then I kind of backed away’ (Male, Northern Highland).

For others it was about learning to trust their own decision making process, in both basic and more advanced situations, with the help of staff at the organisation.

The third aspect of developing a sense of self involves putting the self into action. Of particular importance to the process is that the person recognises that the action arises from their own source of initiative, encouraging a greater sense of autonomy and agency. Again responses around this were numerous. For example, some participants talked about sharing various skill sets with one another and of being inspired to try new things which they previously would have rejected due to lack of self-belief. For others it was about putting forward ideas for improvement of mental health service provision, essentially reconfirming their ability to be active and efficacious:
‘well I noticed that there wasn’t a green gym up here, so I just mentioned to a few doctors and others who were involved with things, and now it’s up and going’ (Male, Western Highland).

The notion of ‘owning’ the action and the importance of that for the recovery process is supported by staff who wait for members to arrive at the next point of discovery themselves. In this way, the process of development is firmly owned by the service user, thereby affirming their own self-efficacy.

The final aspect of establishing an enduring sense of self involves being able to draw on it, as something separate from the illness. The idea of knowing this to be something separate from the fragmented, passive identity that may have previously been experienced, can act as a refuge during times of difficulty, in both the inner and outer world. In particular, it can be appealed to as something that is constant and unaffected by symptoms. According to Davison and Strauss (1992), during times of stress and anxiety, one can appeal to this functional sense of self in order to recall what was previously helpful in such situations in the past. In terms of the voluntary organisations, staff facilitate this process by helping service users to develop coping frameworks in order to understand their ‘triggers’. For some, an awareness of their triggers meant being aware of what has previously kept them healthy at the first signs of symptoms. As one participant noted, when she starts to feel depressed, she makes sure she takes a shower and comes to the voluntary organisation. For others it was about remaining absent from the group for some time in order to avoid unnecessary conflict with others. Essentially, in both instances, there was a recognition that difficult episodes have happened before and have been managed. By doing this, and drawing from their inner self, the voluntary organisations essentially encouraged members not only to become more empowered about dealing with the onset of symptoms but they also helped to build confidence in dealing with similar situations in the future; essentially helping to build resilience in the face of adversity.

Whilst arguably every conscious being has some sense of self, in the context of mental illness this can lead to a loss of self. The onset of mental health problems can often be overwhelming for the individual, involving a severe distortion of meaning that can make the familiar at once unfamiliar and threatening (Estroff 1989). The more severe manifestations of mental ill-health can often strip people of their individuality and leave them with an on-going struggle to reconcile the meaning and place that their experiences of mental distress have in their overall life story (Adame & Hornstein 2006).
ramifications of such a process cannot be underestimated in terms of its impact on personal identity; it (i.e. the mental illness) often becomes entwined with individual identity, so that the distinction between the two becomes lost (Wisdom et al., 2008) or the sense of self becomes lost in the chaos and unpredictability that the symptoms bring (Adame & Hornstein 2006).

This section on gaining control has demonstrated that the voluntary organisations encourage members to connect with their sense of self and is considered to be an important benefit in terms of membership.

6.4 Theme 3: The Centrality of Relationships

Theme Three focuses on the importance of relationships for members. As this section reveals, relationships were seen as crucially important for members, both with each other and with staff. Discussions around this theme mostly centred on supportive relationships at the voluntary groups as a way to maintain good mental health; thus being around others was rewarding. However, as Sub-Theme 3B demonstrates, conflict between members does occur. This section demonstrates how careful negotiation is required in order to manage social relations.

Relationships are a key mechanism for facilitating recovery and is made up of the following Sub-Themes: 3A) ‘We all help each other’; 3B) Relationships outside the voluntary organisation; and 3C) Negotiating Boundaries.

6.4.1 Sub-Theme 3A: ‘We all help each other’

A key finding in terms of the utility of the voluntary organisations is their provision of peer support. Participants highlighted the value of being able to connect with others in a mutually supportive environment. In particular, regularly connecting with others who had experienced a mental health problem allowed members to support each other based on the principles of mutual responsibility and respect (Mead et al., 2001):

‘you don’t have to give your life story, there is that understanding that we all do have a life story and I think that makes a difference’ (Female, Lower Highland).
'we understand more than what other people do what we’re going through [...] so it’s not just the staff who are supporting us, we’re supporting each other’ (Female, Western Highland).

A key aspect to the above comments is that being around others who had experienced a mental health problem allowed members to support each other in trust and friendship, which is an important component of healing (Slade 2009b). Indeed, this can often be challenging in rural environments where greater distances and dispersed populations can limit the development of social links and networks (National Council for Voluntary Organisations 2003). For participants, knowing that they could be open and honest amongst likeminded people acted as a ‘safety net’ that allowed them to feel supported both in the voluntary group and in their own personal life. Again, this is arguably more important in a rural context, where social isolation and stigma form the reality for many service users (see Chapter 4). Connecting with each other in this way also removed any notions of hierarchy:

‘I’ve been in [the local mental hospital] a few times, and [...] when you go into the smoking room, there’s more therapy done in there with all the patients because there are no doctors there. It’s the same with [this organisation] there’s no ‘them and us’ and people will speak to you’ (Male, Lower Highland).

Thus, empathy, trust and respect; the idea that all are considered equal promotes a positive culture of healing amongst members (Jacobson & Greenley 2001). For the vast majority of participants, the support of peers was believed to be as important as support offered by formal mental health services.

For some participants, the friendly atmosphere and the feeling of being welcome was a key attribute in terms of feeling able to connect with others (Coatsworth-Puspoky et al., 2006):

‘I felt really scared when I came here [...] but as soon as I started coming to every group [...] I felt more safe…secure’ (Male, Northern Alberta).

Discussions about relationships with others at the voluntary organisations suggested that looking at other peers as positive role models can give emotional insight and encourage the individual to recognise their ability to cope with the illness and develop a sense of self-worth, as well as a desire to help others (Schön 2010):

Extract: 3 (Northern Alberta)
Male 1: because of this place, I’m slowly getting rid of that [anger] even these guys (points around the room) they’ve helped me out so much

Male 2: But you’ve helped us too […] it’s a two-way street…..I mean just coming here and sitting and having a coffee, and talking with him (points to Male 1) and he comes out with something to do with his own situation, and I look at him and I say, ‘my gosh, that would be a really good idea…I’m gonna do that’….I’m stealing from him, his ideas that he’s got to help himself

In the above exchange there is the recognition that there is mutuality in terms of helping each other to grow: both participants acknowledge the help of the other on their journey. In the second comment (Male 2) he clearly expresses the way in which he gains insight and inspiration around coping with his own problems directly as a result of engagement with the other participant.

Connecting with others in this way is particularly important in terms of facilitating recovery (Davidson et al., 2006b). Given that many people who experience mental health problems have also experienced stigma and social exclusion (Ochocka et al., 2005), the importance of environments that foster close bonds and support should not be underestimated (particularly in a rural context). The benefits of peer support are numerous including increased self-esteem (Verhaeghe et al. 2008; Sadaaki et al. 2010) and improved quality of life (Bouchard et al. 2010); in this way mutual help can facilitate inner healing resources for the individual (Corrigan et al., 2005). Within this framework, providing support to one another is seen as a crucial element that facilitates recovery (Davidson et al., 2006b; Schön 2010). As the data above reveal, participants highlighted the unique element of peer support, namely that only those who have experienced mental illness can really understand and appreciate what others are going through; supporting each other comes from a deep understanding about the feelings of despair and helplessness that often accompanies mental illness. A further element here is that rural service users have a keen understanding of the challenges that fellow rural service users face in terms of trying to maintain anonymity, the prevalence of gossip networks, the implications of being visible (as a person with mental health problems) and the lack of mental health support.

However, whilst a number of academics have acknowledged the importance of peer support for recovery, the evidence lacks detail in terms of how such relationships develop, or what factors influence the relationship. Coatsworth-Puspoky et al. (2006)
have addressed this gap and identified key phases through which peer support relationships develop: i) needing something and exploring, ii) establishing the connection and growing with it and iii) growing away from it. In terms of the current study, in the initial phase feelings of uncertainty and nervousness (i.e. at joining the organisation) are allayed by the friendliness of other members and the welcoming atmosphere at the organisation:

‘in this place […] as soon as a stranger walks in, [members] will go up and ask them who they are, welcoming them’ (Male, Western Highland).

As a result, the new member feels welcome and safe; the relationship then progresses to the middle phase (ii establishing the connection and growing from it). This phase is composed of two sub-phases. During the first phase, establishing the connection, members are able to meet others and hear their stories, which can inspire them to overcome their challenges whilst still pursuing their dreams. In this phase, empathy and understanding are key factors that can help to move the relationship forward:

‘we understand more than what other people do what we're going through […] basically we can offer each other support as well’ (Female, Western Highland).

In this example, experiential knowledge related to mental illness creates a ‘bond’ with other members, essentially helping to establish a connection, or as one participant noted, ‘it made you feel like you’re one of the family’ (Female, Northern Alberta). In this way, the importance of feeling accepted amongst likeminded individuals was crucial for the development of peer support relationships and for facilitating inner growth for members.

In the latter sub-phase, the establishment of connections with others at the group (that encouraged growth) move beyond relationships as members, towards more solid relationships akin to companionship. Within the study, feeling cared for, valued and related to as a human being (‘we still have a heart that’s beating’ Female, Western Highland) by other members was key for helping service users to grow and be able to take increasing control. In Extract Three (above), the participant clearly states the way in which there had been growth in his outlook as a direct result of the friendship and support he received from the other member, again reaffirming the importance of solid connections as a way to achieve growth. Moreover, for some, growth was linked with empowerment:
‘When you’re on your own [it can be isolating], the empowerment comes when other people are standing with you’ (Female, Lower Highland).

‘the people here forced me to get over the ‘poor me’ (Male, Northern Alberta).

According to Coatsworth-Puspoky et al. (2006) in the final phase (iii growing away from it) solid and trusting connections result in self-confidence and satisfaction leading to a gradual separation from peers and/or the group. This final phase was not discussed in the focus groups but it is arguable that growing away can be understood as synonymous with gaining control and having less of a need to attend the group on a regular basis:

‘I use to come down [...] before the key was in the door but then I kind of backed away’ (Male, Northern Highland).

In this way, mutually supportive peer relationships allowed members to heal and grow.

6.4.2 Sub-Theme 3B: Negotiating Boundaries

Whilst peer support based on empathy, trust, mutuality and egalitarianism (Faulkner & Kalathil 2012) facilitates healing and growth, it can imply that all members get along with one another and arguments are rare. However, the data reveal that relationships within the voluntary organisations are not always harmonious and, in some instances, can lead to conflict:

‘if I’m in a really grumpy mood, better not to be around them’ (Female, Southern Alberta).

‘if we’re having a conflict with another member and we don’t know how to handle it [...] we can ask a staff member to mediate’ (Female, Northern Alberta).

These examples show that members have to learn to negotiate boundaries with one another to ensure their continued engagement with the voluntary organisations. Other examples of negotiating boundaries included not asking directly about diagnoses, ‘you never ask anybody about their mental illness’ (Male, Western Highland). There was also a mutual understanding that ‘what happens in here, stays in here’ (Male, Northern Highland).

Resolving these tensions involved various strategies: for example, avoiding another person until things have settled down and asking staff to intervene. There was also an implicit understanding that, whilst service users could express themselves as they wish,
some behaviour was not acceptable at the organisation. Additionally, negotiating
boundaries with one another was directly linked with potential threat (Burns et al., 2002a,
p. 14) due to the unpredictable nature of some illnesses. Being around each other
regularly allowed for an understanding of mental state and hence ‘being prepared’:

‘different people have different problems, and […] I’m learning how to
respond properly to those things’ (Male, Northern Alberta).

In the following extract (Extract 4) participants note the lack of commonality with some
members (Burns et al., 2002a) due to the feeling that their motivation for attending the
organisation was not necessarily driven by mental health needs:

**Extract: 4 (Northern Highland)**

Female:    you have to be careful about what you’re saying…that other people don’t
           try and copy what you’re saying

Researcher: Would anyone else agree with that, do you feel better informed about
           mental health generally or do you think otherwise?

Male 2:    I think most of the people here are well informed, some I’d go as far as
           saying are too well informed about things

Male 1:    When [he] says ‘too well informed’ that wouldn’t be through doing
courses in mental health training […] it would be merely through abuse,
by being observant, listening to other people, about how they fill in forms,
etc.

Male 2:    I think what we’re trying to say is, people are using the centre for their
own ends […] for getting their benefits…and there’s nothing, absolutely
nothing, anyone can do about it

The above comments suggest that being part of a mental health organisation requires
members to learn how to exist together in the same place. Also, it demonstrates that
members are experiencing different degrees of wellness in addition to illness (Burns et
al., 2002a, p. 16) which can, in some instances, cause conflict and tension. However,
feeling a deep connection with members that is based on mutual experience encourages
trust to develop. Consequently, this allows members to respectfully challenge each other
when they find themselves in conflict (Mead et al., 2001). Indeed, the underlying
premise of many mental health voluntary organisations is that they encourage and accept
diversity rather than homogeneity. Within this model, members are encouraged to go
beyond the ‘mental patient’ label towards a more empowered identity. However, in order
to do this, they need to enact these new identities within a context of safety and mutual
support (Mead et al., 2001); moments of tension and conflict may therefore be expected
as members grow in the direction of their choice and embrace their individuality.

6.4.3 Sub-Theme 3C: Relationships outside the voluntary organisation

For some participants, the voluntary organisations had also helped them with other
relationships, both personal and professional. This sub-theme arose from participant
descriptions of the many ways in which the organisations had helped them. Some, for
example, commented on the way in which the support from the voluntary group had
given them the courage to reach out and heal old wounds with family members:

‘through this service I’m getting help with dad […] now the trust, which takes
such a long time to build, is starting to grow’ (Male, Northern Alberta).

‘I have multiple sclerosis….I have one daughter that I know has it for sure but
she’s in total denial [and] I have another daughter that I’m pretty sure has it […]
they’re in denial but I’ve been able to try and talk to them and help them, and it’s
because of this place’ (Male, Northern Alberta).

In the first quote, the participant had been able to see the way in which his old habits and
old ways of being had been detrimental for family relationships. Key to this process was
that healing (as a result of his connection with the voluntary group) had allowed him to
develop a perspective on the past (Turner-Crowson & Wallcraft 2002) and
understand/acknowledge the consequences of his actions. This in turn had empowered
him to take responsibility (i.e. building bridges with family members) in order to gain
control and rebuild a meaningful and valuable life.

In the second quote, the participant felt empowered to try and help other family members;
it essentially allowed him to feel ‘useful’, to step outside of the ‘sick role’ in order to be
helpful to others, rather than simply a passive recipient of services (Turner-Crowson &
Wallcraft 2002; Shepherd et al., 2008).
Additionally, attending the voluntary organisation helped one participant’s relationship with other rural health services and professionals. In particular, the support from the voluntary group had empowered her to speak up if she was unsure about anything:

‘Well I’m more outspoken [now.] if something’s said at CPA I don’t like I’ll say to my CPN […..] or I’ll say it to the Consultant and she’ll explain what it means […] years ago I would never have done that. I would have just come away and bad mouthed them’ (Female, Northern Highland).

In this example, the participant reflects on the way she has grown in confidence (‘years ago I would never have done that’), evidenced by the way she now felt able to assert herself to authoritative medical figures. Her membership to the organisation had encouraged her to move from a passive recipient of care to an empowered individual who is engaged in the decision making process (Farkas 2007).

The above comments about relationships outside the voluntary organisation did not feature significantly in the focus group discussions, evidenced by the small number of quotes. However, the centrality of relationships for the recovery process is a recurrent theme in the literature (Turner-Crowson & Wallcraft 2002; Borg & Kristiansen 2004; Schön et al., 2009; Shea 2010). The onset of mental health problems can have both direct affects (personal trauma, confusion and disruption to living patterns) and also indirect affects in terms of relationships with others (Malpas & Weekes 2001). In particular, serious mental health problems can have a profound impact on the family and friends of the service user (Repper & Perkins 2003, p. 124) leading to reduced social networks; the remaining relationships are then vital (Slade 2009b). This section has, therefore, shown that being able to forge meaningful relationships with others was a key benefit in terms of membership and one that facilitated recovery for members.

6.5 Summary of Part 1

Part One of this chapter discussed the benefits for service users of attending voluntary groups in remote and rural areas (research question 2). Amongst participant descriptions, the key benefits were feeling accepted; meaningful activity; motivation; promoting independence; learning coping frameworks; supportive peer relationships; learning to negotiate boundaries with other members, and relationships outside the voluntary group. These benefits were grouped into three main themes each with associated sub-themes. Analysis of the data has shown that these benefits can be interpreted within the recovery paradigm. A key contribution from this research, therefore, is that rural mental health
voluntary groups promote recovery for members by providing a site for meaningful engagement (Theme 1), helping members to gain control through the recognition of personal autonomy and agency (Theme 2) and by providing a safe place for supportive relationships to develop (Theme 3).

**Part Two**

Part Two presents data on the differences between rural mental health voluntary organisations and other rural mental health services from the perspective of service users.

### 6.6 Theme 4: Relational Continuity

So far, the focus in this chapter has been with issues concerning the benefits for service users attending rural mental health voluntary organisations. Part Two of this chapter illustrates how rural voluntary groups offer something that other mental health services do not by adopting a person-centred approach that, in particular, encourages risk taking and restores hope. As in Part One, the concept of recovery is used to understand the nature of the rural voluntary organisations’ contributions. The first major theme identified here (Theme 4) chiefly focuses on the importance of familiarity between members and staff, this was found to be a key way in which members felt supported and helped. Familiarity and trust in the predictable nature of the relationship evidences considerable therapeutic benefits for participants as shown by each of the Sub-Themes: 4A) Familiarity with Staff; 4B) Being alert to signs of mental distress; 4C) Caring Practices; and 4D) Restoring Hope.

#### 6.6.1 Sub-Theme 4A: Familiarity with staff

In comparison to other mental health services, participants felt their relationships with staff at the voluntary organisations were stable and predictable, and less likely to change which was an important factor for building trust. Many participants also felt they could relate to staff in ways that they could not with other mental health professionals:

*I’m getting passed from pillar to post [...] but this place is like one on one, so you can just talk to one person constantly if you feel you can trust that person [...] if you’re getting passed from pillar to post by these professionals you are going to keep shutting down constantly* (Female, Western Highland).

*I went through that in Aberdeen [...] getting passed from pillar to post and then you just give up, and you just go back to drinking for months on end and then just*
land in hospital and they transfer you to a psychiatric hospital’ (Male, Western Highland).

In the above quotes, the emphasis is on repeated changes of staff as a major area of discontent (Jones et al., 2009). There is a sense from these quotes that a lack of continuity of care can lead to a feeling of helplessness (‘you just give up’ Male, Western Highland) and frustration, ultimately resulting in a lack of investment in the relationship with the next professional they encounter (‘shutting down constantly’ Female, Western Highland). In the second quote, being moved around ‘from pillar to post’ (Male, Western Highland) was particularly detrimental to the participant’s wellbeing, causing him to engage in destructive behaviours.

Additionally, there is a sense that the relationships forged between staff and members are different to those with other professionals. In particular, it seems that such relationships are less hierarchical and are based on empathy and trust (Scottish Recovery Network 2008):

‘I have people involved in clinical services that I haven’t felt I could talk to about everything in the way that I do with [the manager here]’ (Female, Southern Alberta).

‘the relationship I have [with staff], it’s just as if I’m talking to another family member’ (Female, Southern Alberta).

‘you don’t really know the psychiatrist in the same way as you know [the staff here]’ (Female, Southern Alberta).

Having a relationship with a specific professional (i.e. staff member), allowed members to feel consistently supported and to know they could contact that person as and when they needed:

‘I know if I’m ever in trouble I can phone [one of the staff] and I know that they will go out of their way to help’ (Male, Northern Alberta).

There was an implicit understanding that such relationships were long-term and, therefore, not transient in nature; in other words, the relationship was unlikely to be disrupted in the same way as their relationships with other professionals within the mental health system.
The concept of continuity of care has assumed a prominent role within the context of mental health, given the deinstitutionalized landscape and the scope of care provision in the community (Freeman et al. 2002). The term refers to various aspects of care such as whether an individual consistently engages with the same staff, the ability of services to continuously monitor patients, co-ordination between services and professionals, and co-ordination with informal and formal carers outside specialist services (Johnson et al. 1997). The above quotes reveal the importance of seeing the same staff (relational continuity) for individual wellbeing and how regularly interacting with the same staff over extended periods of time was found to encourage an emotional investment from the service user based upon trust and genuine friendship. As mental health care and GP provision are currently being reduced at the local level (Voices of Women in Rural Scotland 2012) the opportunity to establish long-standing relationships is therefore highly salient.

Maintain a therapeutic relationship with staff as an aspect of continuity of care is therefore considered an essential aid to recovery and to overall improved quality of life (Catty et al., 2011). Other research that looked at long-term relational continuity between clinician and service user found that it encouraged trustworthy, collaborative relationships leading to good mental health outcomes including overall recovery (Green et al., 2008). Whilst the process is complex (Catty et al., 2011) analysis of the data reveal that familiarity and trust in the predictable nature of the relationship were the most important aspects for participants.

6.6.2 Sub-Theme 4B: Being alert to signs of mental distress

Another example of the person-centred approach that emerged strongly in the data was building strong trusting relationships with staff. This allowed staff to keep an eye on members in order to be aware of when they may not be themselves. For participants, being monitored in this way was found to be important for their care because they were not always able to recognise when they were becoming unwell:

‘you don’t think [the staff are] watching you but they are’ (Male, Western Highland).

‘the staff here get to know members personally and intimately…and they’ll know when something’s going wrong’ (Female, Northern Alberta).
Familiarity therefore allowed staff to anticipate a crisis and to respond accordingly. Further to this, differences in the level of contact (between the voluntary groups and other mental health services) were key for developing these preventative strategies (Jones et al., 2009):

‘staff can observe you on a continual basis...and [primary] mental health services are very good but they just see you maybe once a month, and they miss a lot of what is happening’ (Male, Northern Alberta).

‘the [staff] here get to know [members], whereas with primary services they don’t, because you just don’t have enough time with them’ (Male, Northern Alberta).

These observations are particularly important to note given the shift towards prevention and lower-level intervention evident in mental health policy (‘No Health Without Mental Health’ Department of Health 2011a; Delivering for Mental Health Scottish Government 2006a). Whilst there are considerable economic benefits in responding to mental health needs at a lower-level (Department of Health 2011b), there are also tremendous benefits to service users in terms of their recovery. As previously noted, recovery is taken in this study to be a process (personal recovery) and not an end point (clinical recovery). Within this framework, recovery is not about the absence of symptoms, indeed relapse is taken to be part of the person’s journey, the most essential aspect is that the individual can attain a satisfying and meaningful life in spite of those symptoms. In terms of the above quotes, the informal monitoring by staff provided psychological reassurance that there was support and help available to assist members in coping whether they were in an acute phase of their illness or not: stability even during times of disruption (Davidson & Strauss 1992).

Being alert to signs of relapse offered an important way for staff to be able to assist members in identifying early signs thereby encouraging them to monitor their own experiences:

28 Within this strategy, a number of supporting documents have also supported this preventative approach in mental health care, see Talking therapies: a 4 year plan of action’ and ’Making mental health services more effective and accessible’;

29 See also ‘Realising Potential’ (Scottish Government 2010c)
'being observed is important because maybe [the staff have] observed something that we’re missing because we’re crashing or whatever.....and they can make a suggestion’ Female, Northern Alberta).

Indeed surveys that have examined what people want from services have repeatedly shown that they desire control over their symptoms, to be able to predict relapse, and to manage crises (Mueser et al., 1992). For members, being able to recognise their ‘relapse signature’ (Repper & Perkins 2003) can, therefore, be an important way to help them gain feelings of control. Informal discussions with mental health professionals also confirmed this.

6.6.3 Sub-Theme 4C: Caring Practices

The following sub-theme focuses on the caring practices of staff. Whilst participants felt that other mental health professionals were caring, there was a general feeling that staff at the voluntary groups tended to go over and above what was expected of them in order to provide care. Examples ranged from practical support, such as form filling, to facilitating access by collecting members from their homes. Given the rural context of this study and the limited level of service provision, such practices were considered extremely important by members.

In discussing what the voluntary organisations meant to participants, it was noted that staff were critical to their success and to participant wellbeing. As previously highlighted (Chapter 4), rural service users are often socially and geographically isolated. The organisations are, therefore, an important source of emotional and practical support, specifically through the caring practices of both staff and members (Burns et al., 2002a, p. 11). For the majority, it seems that staff regularly went beyond their expected roles to facilitate care for service users:

‘they give it 200% all the time’ (Male, Northern Alberta).

‘when I first came here, if I didn’t appear for three days they would phone me up’ (Male, Western Highland).

Staff also provided practical support for members through, for example, filling in forms (Burns et al., 2002a) which was immensely helpful in terms of navigating the benefits system:
‘you get support as well, especially with filling in forms which I just can’t handle’ (Male, Western Highland).

‘the staff here will help members find a place, help them to get on AISH [Assured Income for the Severely Handicapped] help with all kinds of paperwork’ (Female, Northern Alberta).

For some Highland participants, caring practices by staff included going to pick members up to take them to the group or by providing necessary resources in the form of cooked meals:

‘they got me a wee scooter but before that if I phoned them they would come up for me’ (Male, Western Highland).

‘I can phone one of the staff and wait down the bottom of the drive for someone to pick me up’ (Male, Western Highland).

One organisation in the study was able to reach people, and encourage them to feel connected to the organisation, even though they were housebound due to mental health problems:

‘some people with mental health problems, they’re not so active, either physically or mentally, all you have to do in [this organisation] is give your name and address […] Then you get all the reports and everything’ (Male, Lower Highland).

For other participants, the way in which staff shared information with other health professionals appropriately (informational continuity) was a key way in which these caring practices were demonstrated:

‘if I’m having a problem here and [the manager] is aware of it, she’ll call mental health and talk to my worker’ (Female, Southern Alberta).

‘the manager has gone over with people from here to see the psychiatrist and [that way] they get to know from both sides’ (Male, Northern Alberta).

The above points taken on even greater significance when combined with the themes identified in Chapter Four. Such caring practices by staff can therefore become the main source of support for those with limited options. In terms of practical support, this can be vitally important. It can often be overwhelmingly difficult and stressful for service users to fill in forms and deal with official organisations. Indeed, knowing there is practical
assistance available in dealing with officialdom can also have implications in terms of preventative care. As Burns et al. (2002a) note:

'It can be argued that the practical support offered by drop-ins maintains people within the community, saving people from some of the stress and worry which ordinary everyday activities can provoke. In so doing, drop-ins are not only supporting individuals but are feeding into a wider network of service provision aimed at fulfilling the policy of community care favoured by previous and present governments and keeping interviewees out of hospital' (Burns et al., 2002a, p. 12).

In the current policy context, such practical support is arguably even more important, yet, it also has implications for the sustainability of such rural organisations. Under the current welfare reform, for example, eligibility for benefits under the controversial Work Capability Assessment (WCA) has been a source of fear and stress for vulnerable claimants, with those who are found fit for work having to seek advocacy from charitable organisations in order to help with the appeals process (Domokos & Butler 2012; Royal College of Psychiatrists 2013b). This puts further pressure on voluntary organisations due to a lack of resources to deal with such demand (Scottish Council for Voluntary Organisations 2013). In a rural context, where voluntary organisations are often relied upon to provide health and social care (Dickinson et al., 2012), such changes are potentially even harder hitting.

The above comments reveal the way in which the rural voluntary organisations operate through a 'philosophy of care' (Repper & Perkins 2003). From this approach, members are actively encouraged to feel valued and included through the promotion of caring practices, such as ensuring physical access to the organisation (e.g. collecting members from their homes) and also by ensuring access to state organisations (i.e. the benefits system). Operating under such a philosophy can be seen as paramount in terms of facilitating recovery: knowing that others care and will go out of their way to connect with them sends a clear message to members that they are valued. Thus, such a philosophy of care prioritises access and inclusion as a way for members to maintain or regain valued social roles and activities.

Caring practices that facilitate access and inclusion for rural service users take on even greater significance when seen in relation to the views of service providers on accessibility:
‘the needs are probably greater in rural areas…because they can’t pop here or pop there…or there isn’t a bus service, it’s the fact that the infrastructure isn’t even there to let them get from A to B’ (OT, Highland).

Even when attempts have been made to bring service users together, the process has been hampered by stigmatising attitudes from local business owners:

‘Some hotels in Inverness that I’ve been to are very good but it’s not everyone that is willing to accept the client group that we have you know. It’s their perspective too of ‘those loons coming in’ […] we’ve moved the group because it just didn’t gel in a particular situation’ (OT, Highland).

More generally in Highland it was felt that there was not a good distribution of services, with most being centrally located in Inverness (Burns et al., 2002c):

‘Inverness is well supplied […] despite the fact that things were trying to be decentralized, it’s still very much that Inverness has the services and outwith Inverness, Ross-shire and north do not have the services […] there’s just not a good distribution of services at all’ (OT, Highland).

In some instances, this had led to over-referrals to some services, or delayed applications for Guardianship Orders (in cases where a person lacked capacity):

‘[In Highland] the GP is the gateway to most health services […] the GP themselves don’t have difficulty at all referring people in [to this service] and I think sometimes, because there isn’t anything else up here […] we get quite a lot of referrals that aren’t appropriate and should have gone somewhere else’ (CPN, Highland).

‘the problems we have rurally here, would be that if someone is up in New Craigs [based in Inverness], their doctor won’t travel to New Craigs to provide a report […] For Guardianships […] we have had incidents where applications have fallen because the GP won’t travel to Inverness to do the report’ (MHO, Highland).

In Canada, there were also examples of professionals refusing to attend rural areas:

‘[The problem] for us…right now it’s access to psychiatry […] we were left without anybody, for almost a year […] I was phoning, begging for someone to come here’ (Intake Co-ordinator, Alberta).

‘when I went to [provide suicide training at] Rocky Mountain House I said, ‘you know, there’s actually people whose mandate it is to do this type of training’ […]
but they said, ‘it’s not easy to get people to get out here’ […] I found that funny because if it’s your mandate to go out then […], that’s your mandate’ (Counsellor, Alberta).

Because of the time and distance it takes to see an individual, professionals in both Highland and Canada felt limited in their ability to respond flexibly and appropriately, particularly to crisis situations. In Highland, the implications of time and distance in relation to those in crisis was highlighted in a report by the Remote and Rural Areas Resource Initiative (RARARI), which found that significant delays in the transfer of acutely disturbed patients was not uncommon in the Highlands. In particular, factors such as physical distance, escort arrangements and transport infrastructure meant that those presenting as unwell were often held in police cells as a temporary solution until they could be transferred to a receiving hospital (Remote and Rural Areas Resource Initiative 2003).

Such findings, therefore, highlight the importance of organisational caring practices given the wider issues of access, common to both Highland and Canadian rural service users, and highlights the differences between the contributions of rural voluntary groups compared to other rural mental health services.

6.6.4 Sub-Theme 4D: Restoring Hope

The following section focuses on the theme of hope. For all participants that took part in this study, there was overwhelming agreement as to the pivotal role the groups played in their life. This was most clearly expressed when contrasted with where they would be without it. The clear theme here is that the voluntary groups formed a central aspect in terms of members’ everyday lives. Whilst many participants noted that they were receiving mental health support from other sources such as psychiatry and community psychiatric nursing, there was a general feeling that it was the voluntary organisations that formed their ‘lifeline’ and essentially restored hope.

Connecting with the same staff on a regular basis meant the role of the voluntary organisation was about more than its official designation for participants. For the vast majority, it was a lifeline that ensured members felt supported in both their inner and outer world, even during times of relapse. Indeed when asked where they would be without the service, the majority of participants stated they would have committed suicide or that they would be alone and isolated. In this way, the service was conceptualised as something that was deeply personal and of central importance:
‘If [this organisation] was not here, I would be in my apartment, confined’ (Female, Southern Alberta).

‘[if this service was not available] I would be dead, I’m telling the truth’ (Female, Western Highland).

Whilst it may be difficult to quantify such subjective reports, for some participants, there was a direct relationship between membership of the voluntary organisations and admissions to hospital:

‘I was in and out of the psych unit pretty much steady for three to four years……and then I came here, and I’ve been here 25 years….and since I’ve been participating in programmes like [this organisation] I have not been hospitalised once for psychiatric reasons’ (Female, Southern Alberta).

‘I just happened to stop by here […] walked in […] and I’ve been coming ever since…..and it’s kept me out of the hospital’ (Female, Northern Alberta).

In the above quotes, there is an intrinsic notion that the voluntary organisations restored hope for members and it is here that their valuable contribution within the mental health landscape is particularly worthy of note. The notion of hope is a central theme that runs throughout much of the literature on recovery (Jacobson & Curtis 2000; Moore 2005; Slade 2010). As a concept its meaning varies, however, it is closely linked with ideas such as optimism, fulfilment and improvement: ‘[hope is] the fundamental knowledge and feeling that there is a way out of difficulty, that things can work out, that we as human persons can somehow handle and manage internal and external reality’ (Lynch 1965 cited by Larsen & Stege 2012, p. 45). The onset of mental illness can often create despair and anguish for an individual, leaving them with a perceived loss of purpose and meaning in life (Deegan 1988; McGrath & Jarrett 2004). In such a situation, the challenge to create a positive future can seem insurmountable, leading to the abandonment of hope. Moreover, an accumulation of traumatising and devaluing experiences can leave service users with a proclivity to avoid engaging with services or professionals in order to negate further hurt and disappointment (Repper & Perkins 2003). In a rural context, stigma and discrimination from the local community can compound social isolation and reduce feelings of hope.

Despite its elusive nature, hope can be seen as the life force which inspires people to keep going on their journey, as the central component in all personal journeys of growth and
development. For those who experience the catastrophic effects of mental illness, hope is the key that can bring change. As Repper & Perkins (2003) suggest, ‘For people with mental health problems, hope lies at the heart of the individual’s ability and willingness to take on the challenge of rebuilding and recovery’ (p. 52). In terms of the voluntary organisations, the findings demonstrate that they provide meaningful hope that is grounded in the values and experience of service users. Specifically, providing a caring space within which the lived experience of mental illness is normalized inspires members not to give up. Often hearing hopeful stories can inspire others to feel more hopeful (Edey & Jevne 2003) and in a similar way to rebuilding a sense of self, hope can often be about learning from suffering. Voluntary organisations provide a space in which members can realise that failure is also part of the process; that even if goals are not achieved, it can open up new pathways. Consequently, by building on each person’s strengths and motivations, the voluntary organisations are able to create expectations among service users and encourage more reflective processes that allow members to identify possibilities, even in the midst of difficult situations. Additionally, staff focus on the strengths and abilities of members, which can often be overlooked in clinical assessments (Rose 2001).

There is a sense in the data that for participants, restoring hope was not about the elimination of symptoms, or the idea that they would not relapse, but about the ways in which they were able to continue to face on-going challenges (see sub-theme 2B ‘Encouraging Coping Frameworks’). However, this demonstrates the importance of feeling optimistic about the future: hope creates a future-orientated expectation of attaining valued goals that will restore meaning to one’s experiences (Schrank et al., 2008)\(^\text{30}\). In the focus group discussions, restoring meaning to previous experience was seen to be facilitated through forging personally valued social roles within the organisation with staff and other members.

6.7 Theme 5: Individualised Care

In the wider literature, voluntary organisations are widely accepted as framing their service within a person-centred approach. Data from the current study reveals this approach fosters inclusion and a sense of connectedness for members, as the second sub-

\(^{30}\) The process of recovery in mental health is based on restoring meaningfulness or attributing new meanings to one's past experiences, in this way hope is the prerequisite for the process (Schrank \textit{et al.}, 2008)
theme (5B) demonstrates, taking the time to know members individually can also encourage positive risk taking, ‘out of your comfort zone’ (Male, Lower Highland). Given the impact of stigma processes for rural service users highlighted in Chapter Four (i.e. distancing by the community or being ‘fixed’ with a mental health identity) involvement with groups that take time to get to know them and value them as individuals can help to ameliorate the impact of such processes for service users. The discussion in this section begins with Sub-Theme 5A) The Dimensions of Giving Time and its Restorative Nature; followed by Sub-Theme 5B) The Importance of Positive Risk Taking.

6.7.1: Sub-Theme 5A: The Dimensions of Giving Time and its Restorative Nature

Many participants felt that a clear difference between the voluntary group and the care they received from other rural mental health services was that staff in the voluntary group had more time for them (see also Burns et al., 2002a, p. 11). Sometimes this could be simply about having time to listen or taking the time to get to know them as individuals:

‘[The staff] will just sit there and talk to you or listen to you’ (Female, Western Highland).

‘when you first come here they get to know you, the point is [mental health professionals] don’t get to know you as an individual’ (Male, Northern Alberta).

‘[the staff] do it with timing and patience….they don’t just write you off’ (Female, Northern Alberta).

The above comments convey a sense that staff are willing to listen to members and their concerns, without feeling rushed. This can also be a source of reassurance (Burns et al., 2002a). As the following quotes indicate, the overriding feeling in clinical settings is one of a heightened awareness of the time that is allotted to the professional:

‘we’ll see a psychiatrist […] every six months for a med review […] we all have our little 15 minute time slot with the psychiatrist, so we’ve got to get everything in during that short time [and it makes you feel rushed]’ (Female, Southern Alberta).

‘[with the psychiatrist] it’s like, ‘okay, you’ve got five minutes’….and then he looks up after like ‘can I do something else for you’….it’s like he doesn’t have time’ (Male, Southern Alberta).
Participants also felt that voluntary organisation staff took the time to help resolve problems, no matter how small they were. Such attention to detail was immensely helpful to members and many felt this was equally as important as clinical input:

‘the staff always say to you, that they’re not professionals, they’re just there to listen […..] and sometimes you just need that’ (Female, Northern Highland).

For some, the lack of clinical training of staff was advantageous as it removed any notions of hierarchy and judgement.

Currently mental health services are often stretched in terms of resources (Centre for Economic Performance 2012) meaning service users are given less time (MIND 2011). Primary care often delivers more mental health care than any other health service (Miller et al., 2011) and yet mental health issues are given limited time during consultations (Tai-Seale et al., 2007). Indeed, despite the importance of having time to talk with someone, professional or otherwise, it can often be lacking from care plans (Rose 2001). From a therapeutic perspective, the act of ‘listening’ is a much under-rated skill (Shepherd et al., 2008); it can help to foster a sense of inclusion and sense of connectedness for service users. As the data from the current study shows, it can also act as a way of increasing self-esteem by reinforcing the notion that service users are worth the time to sit and listen to.

Furthermore, being able to sit and listen while a person makes sense of their distress can be an important step in terms of increasing their sense of self-control (Shepherd et al., 2008).

However, from the perspective of service providers, limited service capacity as a result of resource issues have directly impacted on the time they actually get to spend with clients. Whilst professionals in the study recognised the importance of the social dimensions of a person’s care, increasing pressures around workloads had impacted on the time, or the quality of the time, they spent with clients:

‘[the issue of time] I think that’s a very fair comment because I think that we’re quite driven to be very outcome-orientated’ (CPN, Highland).
‘A home carer used to get about half an hour to go in and see someone [but] these visits [...] have been reduced in time to 15 minutes [...] this is why the whole notion of eating has changed [...] there’s a company [...] who have been given the contract of providing frozen meals for people at home. So now the home carer just has to go in and pop it in the microwave…then ‘ping’ and off they go’ (OT, Highland).

‘[other services] want you here right now and that’s not always possible […] we’re not as reactionary to all of their wants’ (Intake Coordinator, Alberta).

Limited time with clients had implications in terms of building a rapport and establishing trust. In particular, opportunities to do this were felt to be associated with grade:

‘there’s a relationship probably to the grade that they’re at, isn’t there. Whereas the less qualified you are, the more time you’ve got to be with people, and the people they spend the less time with will be the Consultant Psychiatrists. You could argue that the most important people in the decision making process, and have the most power, and see the person for the least amount of time are the psychiatrists’ (MHO, Highland).

Yet having quality time with clients and knowing more about them was beneficial in terms of being able to pass the relevant information on to appropriate professionals:

‘[resource issues] make it difficult because when my staff are looking for support with somebody, at the moment if they go to someone who is a designated Social Worker or Mental Health Officer, who knows that person and knows their background, it’s much easier…than someone who doesn’t know, and hasn’t had that contact with the person’ (Voluntary Organisation Manager, Highland).

In recent years, there have been significant cuts to public sector services in the UK (Evans et al., 2012) with increasing redundancies adding pressure to an already stretched workforce (Audit Scotland 2011). For mental health services, the impact has meant the reduction or closure of day centres, loss of care and support services and reduced access to training and employment opportunities (White 2011, p. 4). Both in Canada and Highlands, rural professionals were dealing with continual restructuring within their respective service which meant that in some instances they were left feeling isolated or understaffed, and with less time to spend with clients (the issue of service resources was discussed in Chapter 5). As the quote above highlights, services such as Home Care that was previously provided by the Local Authority have been outsourced to private care
providers. As a result, the new care provision was considered sub-standard, with a significantly shorter amount of time spent between clients and staff. In some instances, it was felt to have led to the use of overseas workers who were unfamiliar with the language and culture.

The disjuncture between what rural service users want and need, and the current level of service resources is important to note. As highlighted in Chapter Two (p. 43) the concerns with implementing recovery in already stretched mental health services is well documented (Davidson et al., 2006a; Shepherd et al., 2008). Nevertheless, as the data from this section reveal, there are significant therapeutic benefits in terms of giving quality time to service users. It can encourage self-control and confidence, and can be the most important aspect to mental health care. Additionally, giving quality time to service users ensures their needs and wishes are central in the therapeutic process.

6.7.2: Sub-Theme 5B: The Importance of Positive Risk Taking

One group in the study (in Highland) were keenly involved in consultancy work and mental health training (which will be discussed further in Chapter 7). Participants were often given the opportunity to do public speaking if they felt able and ready to. Of particular importance was the idea that taking the time to build strong, personal relationships empowered members to take risks:

‘It was nerve wracking but then I thought, ‘to hell with it, I can do it’ (Male, Lower Highland).

‘It’s more out of your comfort zone than anything’ (Male, Lower Highland).

Responses around the subject of public speaking suggested that it was beneficial for members in a number of ways. It required courage, for example, to stand up and talk in front of strangers about deeply personal issues. Being out of the ‘comfort zone’ can also be important for personal growth and for a sense of accomplishment (‘it was nerve wracking’).

Finally, it can increase self-esteem with the recognition that the audience actually want to hear what members have to say:

‘the empowerment comes when [....] the people that you’re talking to are there because they want to understand’ (Female, Lower Highland).
In the context of recovery, positive risk taking can also be about developing new interests, ‘[because of coming here] I’ve [started] going a lot to the Players Club for coffee […..] I’ve even been doing little bits of work for them’ (Male, Northern Alberta), deciding to act different in a relationship, ‘I’m going to get a lot more involved with the other tenants in my building and it’s because I’ve gotten the confidence from coming here’ (Female, Southern Alberta) or developing and consolidating a positive identity ‘I’m more outspoken [now] I’ll speak my mind more’ (Female, Northern Highland) that lead to personal growth and development (Slade 2009a, p. 177).

Within the mental health system, most notably psychiatry, generalised fear as part of a blame culture, coupled with a legal framework that advocates the reduction of risk, has led to more defensive practice (Kallert 2008). The usual aims of mental health services are generally to control symptoms, stabilise functioning through medication compliance and to ensure safety (Rudnick 2012b). Whilst such aims are important, and it would be unwise to consider otherwise, the tenets of recovery suggest that encouraging positive risk taking is important in relation to personal growth and development. The conditions must be such that a person finds the courage to take calculated risks, and take responsibility for failures, in order to grow (Craig 2008). By increasing the opportunities for taking risks, it can allow service users to assume greater responsibility and control for the decisions they make (Davidson et al., 2006a).

Historically the issue of risk and, by implication safety, has been framed by modern psychiatry in terms of prevention of harm that would be considered intentional and directly caused by the mental illness (Rudnick 2012b): the solution being immediate hospitalisation of the individual. As the locus of care has moved from the hospital to the community, the use of Community Treatment Orders (CTO) has become an increasingly popular means through which risk can be minimised if required (Molodynski et al., 2010). From this it can be seen that risk has been framed as the harm inflicted by service users to others. However, involuntary hospitalisation can be severely traumatising for service users, with some developing post-traumatic stress disorder (Meyer et al., 1999). In addition, the principle of harm to others essentially ignores the concerns that service users have, such as potential risk to themselves in terms of the loss of independence or quality of life which can be brought about through worsening symptoms (Faulkner 2012). Whilst reducing physical risk such as aggressive behaviour is important, the concept of recovery prioritises the personal autonomy of the individual and considers context in relation to personal and environmental risk factors; in other words, one size does not fit
all (Rudnick 2012b). Recovery encourages opportunities for growth and change, and is necessary in order to achieve personally meaningful goals and socially valued roles (Shepherd et al., 2008; Slade 2009a; Rudnick 2012a). However, this also requires a sharing of power, a willingness on the part of the professional to allow service users the right to experience taking risks. Such sentiments are echoed by one service provider in the study:

‘I believe in empowerment….empowerment is a finite supply and so for people to gain power, other people need to give power up. So, you create conditions where people take power, you don’t give power to people….and we as professionals we could all do with being more comfortable with allowing people to take power and to deal with risk in a different way […] in mental health services’ (MHO, Highland).

In this example, there is the recognition that encouraging risk-taking also has clear implications for professionals in the event that things go wrong, however, the key mediator in terms of the risk and blame culture is the media.

6.8 Theme 6: Flexible to Need

This final theme focuses on the importance of having somewhere to attend through the day as a key contribution to overall wellbeing. Given the rural context of this study, having a sense of structure, a place to go and connect with other people can be seen as crucially important, and indeed is a key point of divergence in relation to other rural mental health services. One of the clearest ways that the various aspects of this theme come through is in the way participants contrast the sense of structure and availability to not having it. The overall theme ‘Flexible to Need’ is woven with descriptions that highlight the importance of predictable structure and routine, but also the psychological reassurance that comes from knowing the organisations are there as and when members wish to access them.

6.8.1 Sub-Theme 6A: Structure

For a number of participants, having a place to attend through the day was particularly important in terms of having a sense of structure. Whilst this did not necessarily prevent relapse, having structure to the day helped to mediate against the ‘ups and downs’:
‘if this place wasn’t here, I’d have nowhere to go, apart from meet a friend occasionally for lunch or whatever, but I would be at home, by myself, with four walls and I would just deteriorate’ (Female, Northern Highland).

‘for the first six months I didn’t have a job so I would be coming here every day, without fail, and that’s how I would spend my days’ (Male, Northern Highland).

The above comments highlight the way in which having a sense of structure was important for maintaining good mental health. Much of this overlaps with the previous discussion on the theme of motivation (see 6.2.3), however, the main point here is that the voluntary groups provide a place for rural service users to attend through the day which is something that other mental health services may not be able to provide. For example, some rural mental health services consist of hourly visits once a week (e.g. support work) or monthly consultations with a psychiatrist. Whilst such input is essential, it can leave a gap in terms of providing a daily structure for rural service users. The unpredictable, and sometimes chaotic, impact of mental illness can mean that having a predictable structure and routine is important for getting through the day (Walker 1986; Leete 1989). Within the wider recovery literature, structure is often associated with employment (Repper & Perkins 2003; Shepherd et al., 2008; Swarbrick 2012) Such engagement can be tremendously beneficial for service users on their recovery journey (indeed for some participants in the study, attending the voluntary group enabled them to also maintain a presence at work). However, where this was not possible, the voluntary groups go some way to providing a similar structure.

There is a danger in viewing work as a panacea for mental illness (Shepherd et al., 2008). As Chapter Four highlights, work may not always be a suitable solution during particular times of a person’s recovery journey. It may, in some instances, create additional stress and pressure.

6.8.2 Sub-Theme 6B: Availability

For many participants it was tremendously beneficial to know that the voluntary group was available to access during the day, should they need to, which was often found to be missing from other mental health services. Indeed, some participants who had used urban drop-ins noted the limited availability for members (i.e. only being open on certain days) and the limitations in terms of not being able to self-refer. It was apparent from responses around the subject that participants did not always feel the need to use the
service ‘all day, every day’ but it gave them peace of mind knowing that the option was there. Availability was particularly important during times such as the Christmas period, when the potential for isolation increased. The physical location of the organisation was important in terms of accessibility but psychologically, availability was of most importance:

‘365 days of the year this place never shuts, it is open every single day, you’ll never get that type of support anywhere else’ (Male, Northern Highland).

‘And the members don’t come at 8.30am when it opens, and they’re not here all day…..they come at different times of the day’ (Female, Northern Alberta).

The above comments highlight how important rural voluntary mental health groups are for members. As highlighted in Chapter Four, rural service users are often socially and physically isolated due to the wider physical and cultural environments in which they are located (Burns et al., 2002a). Given the on-going gaps in rural service provision and increasing cutbacks to services (Campbell & Meikle 2011; Asenova et al., 2013) there is a sense that having the option to attend the group whenever members choose is necessary, particularly when members have worries that they need to share with someone or if they need help resolving problems. Some participants also noted the importance of not having to fulfil specific formal criteria (i.e. through a referral system) as a further dimension in relation to availability:

‘When I lived in […], they had a couple of places but they weren’t [like this] you had to be referred and you could only go on certain days […] and it wasn’t open every day of the year’ (Female, Northern Highland).

In Canada, the lack of availability was often cited as the reason why participants had relocated from one rural location to another:

‘[where I grew up] I never had anything like this’ (Male, Northern Alberta).

‘when I was having my problems of old back home, if we’d have had something like this […] I would never have had to come here’ (Male, Southern Alberta).

A further aspect to availability was in relation to staff at the voluntary organisations. For participants, having the option of contacting staff to share worries and concerns was crucial in terms of responding to need, particularly given the limited opportunities elsewhere:
‘if there’s anything bothering me […] I can come down here [and] get off my chest what’s bothering me’ (Male, Northern Highland).

‘if you phone up the mental health team you’re lucky if you get a phone call back that day. Especially if you phone [the main area up here] because there’s no secretary there […] sometimes you’ll get a call back that day, sometimes you won’t’ (Female, Northern Highland).

‘if there’s something that’s on my mind and I need to get it out, I can go to [the manager] first thing in the morning and say, ‘[…] this is what’s troubling me right now’ (Female, Southern Alberta).

Indeed, the lack of availability of formal mental health services was highlighted by a psychiatric nurse in the study:

‘we’ve got our limits of once a week [for contact with the client], if someone really needs the input, any more than that […] it’s really hard to accommodate it….and I think spending time with someone and being able to go out and help develop different interests […] there is very limited use of that here. There’s only one person and, again, he has to spread himself out very thin to accommodate that’ (CPN, Highland).

Hence the theme of physical and psychological availability marks an important point of divergence between the voluntary groups and other mental health services. It would be unwise to assert that other mental health services are not responsive to need. Indeed some services are there specifically for more acute phases of illness (e.g. community psychiatric nursing service). However, it is arguable that immediate availability of environments that help service users to feel both physically and mentally safe is a key aspect in promoting recovery and enhancing quality of life (Swarbrick 2012). Indeed, one initiative in Wales (CREATE) has sought to bring all mental health day services (provided by both statutory and voluntary services) together with the aim of streamlining the process of accessing appropriate help. For those service users in crisis, the aim is to ‘promote a supportive and safe environment’ with a ‘range of therapeutic interventions and activities’ based on the recovery model to ensure individuals can enjoy respite in a non-pressurised setting (http://www.createswansea.co.uk/index.html). Whilst it is unclear how many people the initiative serves, or how successful it has been (i.e. there are no formal evaluations available) it does demonstrate an acknowledgement of the importance of environments that foster recovery when service users are in crisis.
6.9 Summary of Part Two

Part Two of this chapter presented data in relation to the differences between the voluntary groups and other rural mental health services (research question 3). In bringing these differences together, the data reveal the unique contribution of such organisations. In bringing the many themes together for Part Two of this chapter, it can be seen that they can be grouped together under the meta-code of ‘Personalised Care’. As highlighted in this section, such organisations place a strong emphasis on taking the time to get to know members personally. The significance of such an approach cannot be emphasised enough in terms of its therapeutic value. This personalised approach included relational continuity (Theme 4) which: encouraged an emotional investment between staff and members; had implications for lower-level interventions and preventative care; facilitated access through a ‘philosophy of care’; and, restored hope for members.

In Theme Five, the importance of giving time to members was found to be a key point of divergence between the voluntary groups and other mental health services. A consequence of such individualised care was that it encouraged positive risk taking, an important dimension in the recovery process in terms of personal growth (Shepherd et al., 2008).

The final theme in Part Two focused on the way in which such organisations were flexible to need by providing structure and availability for members. This final point is particularly salient in the context of rural mental health. As highlighted in Chapter Two, key issues in relation to mental health service provision in rural areas centre on the themes of access and availability. Further to this, the current public health landscape is characterised by increasing cutbacks to services (Campbell & Meikle 2011; Asenova et al., 2013), making the contributions of the voluntary sector even more vital. In line with this, a number of service providers in the study noted the way in which they were constrained in terms of how much time they could spend with their clients. The issue here then, is not so much that professionals do not want to spend more time with service users, or that they do not recognise the therapeutic value of doing so, it is that limited resources and an orientation towards an outcomes approach dictates the way in which they deliver their services (despite being at odds with what service users want).
6.10 Mechanisms that promote recovery

As previously noted, there is a lack of critical engagement with the notion of recovery as a process (Roe et al., 2007) and how to implement recovery-orientated practice based on the current knowledge base (Davidson et al., 2006a). By considering these issues, the data reported in this chapter illustrates that recovery is promoted by voluntary organisations by:

<table>
<thead>
<tr>
<th>Mechanisms that promote the process of recovery</th>
<th>Impact</th>
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<tr>
<td>Familiarity with staff (relational continuity)</td>
<td>1) Key factors are <em>familiarity</em> and <em>trust</em> in the predictable nature of the relationship</td>
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<tr>
<td>Alert to signs of distress (informal monitoring)</td>
<td>2) provides psychological reassurance that support is available whether members are experiencing an acute episode or not</td>
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<tr>
<td>Caring Practices (‘philosophy of care’)</td>
<td>3) can encourage members to recognise their ‘relapse signature’ essentially helping them to gain control</td>
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<tr>
<td>Restoring Hope</td>
<td>1) sends a clear message to members that they are valued (important for self-esteem)</td>
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<td></td>
<td>2) access and inclusion are prioritised as a way for members to maintain or regain valued social roles and activities</td>
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is normalised is a source of inspiration and hope

2) providing a caring space can allow members to realise that failure is also part of the process

3) by building on each person’s strengths and motivations, the voluntary groups are able to create expectations and encourage reflective processes that allow members to identify possibilities, even in the midst of difficult situations

4) the voluntary groups help to restore meaning to previous experience for members by facilitating personally valued social roles (with staff and other members)

Giving Time

1) Fosters a sense of inclusion and connectedness

2) Increases self-esteem by reinforcing the notion that members are worth the time to sit and listen to

3) Being able to sit and listen while members make sense of their distress can increase their sense of self-control
Positive Risk Taking

1) Personalised approach to care can encourage positive risk-taking, essentially providing opportunities for growth and change (the ‘dignity of risk’)

Structure

1) Knowing there is a place to attend every day (predictable structure) helps to mediate against the ‘ups and downs’

Availability

1) Immediate availability of environments that help members to feel physically and mentally safe is key for the recovery process

6.11 Conclusions

Rural mental health voluntary organisations promote and facilitate the process of recovery for members in many ways. While recovery is deeply personal, the data reveal a number of commonalities for participants in both Highland and Canada. As noted in Chapter Three there are challenges in terms of empirically measuring recovery given that it is highly individualistic and subjective. The external, objective evidence can be linked with reports from the managers of these organisations who note that hospital admissions have been reduced and, in some instances, are shorter in duration for members, and overall, members had achieved greater levels of stability. This type of corroborating evidence is important, given the policy dimensions of this study. However, this thesis aligns itself with the concept of recovery as a deeply personal process, in this way feeling better and enjoying a positive subjective mental state is getting better.

This chapter sought to answer research question two ‘What benefits are there for service users attending voluntary groups in remote and rural areas?’ and research question three ‘Do voluntary groups offer something that other rural mental health services do not?’ In relation to the former, the chapter has shown that the benefits for members were numerous. Rich descriptions from participants highlighted, for example, the power of engaging in meaningful places. Such sites are caring spaces where members are able to connect with likeminded people, in a safe environment, in a way that can often seem too
difficult or challenging in the mainstream. In this way, the organisations allowed members to feel accepted for who they are, essentially helping to ameliorate the effects of social exclusion and stigma highlighted in Chapter Four. This also impacted on the level of motivation that participants had. This is particularly important in the context of rural mental health given the sometimes isolating and vulnerable position that service users can find themselves in. The feeling of belonging and acceptance also encouraged healthier attitudes and a renewed interest in life (internal environment), demonstrated externally through continued attendance at the organisations and also by the way in which members were motivated to connect with the wider community (external environment). Examples in this study included telling others in the community about the voluntary groups to which they belonged.

The support provided by such organisations was crucial for helping members to feel in control of their life. For most, the voluntary organisations were conceived as a lifeline without which they would likely be alone or isolated, or with worsening symptoms. Such findings serve to highlight their pivotal role in terms of rural community-based service provision. The traditional psychiatric approach associates mental illness with the loss of free will and curtailment of personal responsibility. In contrast, the organisations in this study helped members to regain a sense of agency and efficacy, to mobilise internal resources (i.e. confidence, self-belief, the recognition of skills and ambitions) through the recognition of personal autonomy. As the data throughout this chapter demonstrates, the organisations give primacy to lived experience, shaped around the assumption that all participants have something to contribute. On a deeper level, having this opportunity helped members to gain a sense of self and to cognize their mental health problem as forming only one aspect of their identity. Given the tendency for a mental illness status to subsume a person’s identity (Davidson et al. 2005) it becomes apparent why notions such as self-determination and personal actualization are fundamental to recovery (Roe et al., 2007) and why relationships are so important to the process.

In relation to research question three, there were a number of points of divergence between rural voluntary organisations and other mental health services. For example, the personal reach of the voluntary organisations was facilitated by the emphasis they placed on individuality and on the importance of taking time for members. This was often felt to be lacking from other mental health services. This encouraged a sense of connection and inclusion, and highlighted the importance of building strong, trusting relationships with staff (relational continuity) as an aid for recovery (Green et al., 2008). For the voluntary
organisations, it seems this is an important juncture at which they help members. For participants in the study, the notion of staff taking the time to get to know them as individuals, understanding their history, their likes and dislikes, was seen as equally important, if not more so, to relationships with other mental health professionals. Giving time to members meant that staff could nurture what was meaningful to them, essentially inspiring hope.

There were instances of conflict within the study, and it is important to flag these in order to present an accurate portrayal of rural voluntary organisations. However, the overall picture that participants painted was that such personalised care was a fundamental aspect of their overall wellbeing.

It is important to acknowledge that not all service users wish to connect with their peers or be part of mental health communities. Some choose to cope on their own, or with minimal support. Indeed, recovery is deeply personal and attributable to each in different ways and can therefore be just as effective with minimal service input. The evidence presented here, however, relates to the way recovery occurs due to being amongst likeminded people as facilitated through a rural voluntary group.
CHAPTER 7

RURAL MENTAL HEALTH VOLUNTARY GROUPS: KEY CONTRIBUTORS TO LOCAL SOCIAL CAPITAL
7.1 Introduction

This final findings chapter explores whether the concept of social capital is useful for understanding the benefits and the role of rural mental health voluntary organisations. This is particularly relevant given the lack of research into social capital and mental health (McKenzie et al., 2002). The concept of social capital finds its origins in sociology, specifically communitarianism (DeFilippis et al., 2006). Putnam (2000, 2007) expounds the virtues of social capital in terms of the way in which it can build cross-cutting ties and more encompassing identities, which in turn creates socially cohesive and trusting communities. When this concept is applied to physical and mental health it can have important outcomes such as increased life expectancy and enhanced wellbeing and self-esteem (Mckenzie & Harpham 2006; Scheufele & Shah 2000). However, as highlighted in Chapter Two, the conceptual complexity and associated challenges with definition are noted. This thesis has adopted Putnam’s definition that social capital ‘refers to connections among individuals – social networks and the norms of reciprocity and trustworthiness that arise from them’ (Putnam 2000, p. 19).

One of the aims of the current study is to understand the benefits of membership to voluntary groups (linked with wider policy initiatives in Scotland aimed at building healthy connected communities to reduce the incidence of mental health problems). It is therefore appropriate to consider social capital given its focus on community cohesion. The following section presents findings from the focus group discussions with service users, interpreted through a social capital lens and in relation to existing literature on social capital. A point reiterated throughout this thesis is that there is a lack of knowledge on the nature and scope of the rural voluntary sector. Using the lens of social capital, in line with Putnam’s conceptualisation, is therefore useful given the focus that it places on voluntary associations and community cohesion.

This chapter firstly presents the theme of bonding social capital (Theme 1), along with associated sub-themes, before presenting the data on bridging social capital (Theme 2) and associated sub-themes. Finally, the chapter presents Theme Three in relation to social trust.
7.2 Theme One: Generating belonging and group identity: benefits/role

Theme One considers the bonds formed between service users. This was a key theme to emerge from the focus groups because it was discussed at length by participants. This theme illustrates the nature of strong bonds and their importance for service users through the following Sub-Themes: 1A) Group belonging – Family; 1B) Staff Ties; 1C) Public and Private Benefits; 1D) Negative Aspects; 1E) Collective Action and Social Citizenship.

7.2.1 Sub-Theme 1A) Group belonging – Family

The first sub-theme presented here focuses on the nature of social ties between members. In both countries, participants tended to describe the group in terms of ‘family’ or ‘community’. There was also the suggestion that the closeness of the group was of equal importance as relationships with family members. In some groups, this emotional closeness had allowed friendships to extend beyond the organisational settings. Whilst not all members were close, it seems the dynamic of the group encouraged members to have more tolerance of one another, despite varying differences in opinion and outlook:

‘It’s just like we’re all one big family in a way, get on and we all help each other where we can’ (Female, Western Highland).

‘it takes friends, community and a family to make a person well, so like I say [...] we are family, friends and community here’ (Male, Southern Alberta).

‘I enjoy [the discussions I have with another member], even though some of the things we’ll never agree on [...] we can agree to disagree’ (Female, Southern Alberta).

This closeness encompassed a sense of commitment to each other and the group, evident in different ways. In one group, this was expressed in relation to a previous service user who had murdered a member of staff. The discussion around the topic suggested that members had taken the event personally, and somehow felt to blame for what had happened. On the other hand, the closeness of members had allowed them to grieve together and to get through it as a group:

‘a few months ago, one of the workers here was killed by a client [...] we all felt that [...] somehow we had contributed to this thing that had happened because we all knew who these people were….and that was dealt with, privately, in here….and that gave us the strength to move on’ (Male, Northern Alberta).
Evidence of close ties amongst members was also highlighted in another group, when the discussion focused on the potential closure of the organisation. A strong sense of loyalty to the group not only mobilised members to protest against the funding cuts, but also reaffirmed their political voice in the process:

‘The idea that the funding would be either cut or reduced [...] members were absolutely up in arms. [The manager] didn’t have to organise a protest, it just came’ (Male, Lower Highland).

In the above examples, the sense of closeness and emotional connection indicate members have strong ties with one another and a sense of collective identity; essentially bonding (Putnam 2000; see also Chapter 2) social capital.

7.2.2 Sub-Theme 1B) Staff Ties

Immersion in intimate relationships is also important in terms of prevention as it can enhance the likelihood of accessing support, thereby protecting against distress (Kawachi & Berkman 2001). Within the focus groups, participants talked of the importance of accessing help, either from their peers or from the staff at the organisation, if they were experiencing difficulty:

‘if anybody needs help in here [...] they can call on a member [...] in the past I’ve just totally lost it and blew my stack and then talked to the staff and calmed myself down’ (Female, Western Highland).

Being able to draw on the informal support and advice of both staff and peers was an important resource to members (Cobb 1976). The highly bonded nature of each group also meant that members could share their personal stories with one another, thereby widening understanding of mental illness and highlighting different coping strategies (Cohen & Mackay 1984).

7.2.3 Sub-Theme 1C) Public and Private Benefits

According to Putnam (2000), bonding social capital is beneficial for sustaining and reinforcing specific, or personal, reciprocity and for providing members with social and psychological support. It can create ‘powerfully positive social effects’ (Putman 2000, p. 23). The data show that strong social bonds within the group created a community of belonging, a place where members felt part of a ‘family’. Having this sense of security
and acceptance had therapeutic benefits in terms of increased self-esteem for members (private good). It also encouraged trust and a sense of loyalty and solidarity. Whilst these are important on an individual level (private good), there are also wider benefits that were noted (public good). In particular, the data suggest that positive psychological states (such as increased self-esteem) encouraged better mental health outcomes due to increased motivation for self-care (Kawachi & Berkman 2001). For example, one participant noted the sense of belonging he felt with the group discouraged him from lying in his bed and doing nothing (Male, Northern Alberta). This evidence linked with mental health outcomes is important to note given the lack of research into social capital and mental health (McKenzie et al., 2002; see also Chapter 2). In addition, opportunities to build strong social ties can be difficult in rural communities where high levels of stigma can compound the social exclusion of service users and limit their ability to forge friendships.

Thus, group closeness/bonding social capital provides both private and public good for those using rural mental health voluntary organisations. Nevertheless, whilst Putnam acknowledges the role of psychological support and its positive social effects, his exposition lacks detail in terms of how the process works or the nature of the pathway. Theoretical explanation can be drawn from the main effect and the stress-buffering models proposed by Cohen and Wills (1985) (see Figure 3, Chapter 2). According to the main effect model, having strong social support can affect psychological wellbeing in a variety of ways. Participation in social networks can, for example, provide regular positive experiences and a sense of stability. It can also create a sense of belonging and security, along with recognition of self-worth. Integration within a social network may also help to avoid difficulties, such as economic or legal problems, that could adversely influence psychological health. In terms of physical health outcomes, social support can produce emotionally induced effects on immune system functioning and also through the influence of health-related behaviours such as medical help-seeking. This study found that it was not uncommon for the voluntary organisations to provide space within which members could meet their mental health workers (e.g. community psychiatric nurses). The provision of spaces that facilitate the relationship between mental health professional and service user, coupled with an environment that normalises mental illness, meant that help-seeking was actively encouraged.

In terms of the stress-buffering model, strong social support can mediate between stressful events and their impact on the individual. In particular, supportive relations act
as a ‘buffer’ from the ‘potentially pathogenic influence of stressful events’ (Cohen & Wills 1985, p. 310). According to the model, social support can act on a number of points on the pathway between stressful events and eventual mental illness. For example, during a stressful event, understanding that others can provide necessary resources may reduce the chances of a stress appraisal response and thereby prevent an escalation of negative emotional responses:

‘if there’s anything bothering me […] I can come down here and speak on a one to one’ (Male, Northern Highland).

In addition, received support may also reduce the chances of a stressful response by providing solutions to the problem or by reducing the importance of the problem. As previously highlighted, the protective effect of social support in the face of psychosocial stress was evidenced by one group that had suffered the loss of a member of staff under tragic circumstances. The bonded nature of the group was an important resource that helped members move on collectively.

7.2.4 Sub-Theme 1D) Negative Aspects

The discussion so far has highlighted the many and varied ways in which strong group social ties can be beneficial for members and essentially lead to positive mental health outcomes. However, there is danger in assuming that strong intra-group ties are necessarily always good for society. Examples such as organised crime groups are often cited by academics for their potential in terms of negative outcomes that emerge from exclusive networks with strong norms and loyalty (Fukuyama 2001; Ferlander 2007; Moseley & Pahl 2007). In terms of rural mental health, communities that are highly bonded may have less tolerance for those who experience mental illness, and consequently may choose to exclude them (McKenzie 2006, p. 33). Conversely, when organisations or groups bond and make no attempt to connect with others beyond familiar circles, social exclusion can also be a potential outcome (Moseley & Pahl 2007). Such examples serve to highlight the complexity of bonding social capital in relation to social inclusion. Within the context of mental health these are particularly important points to acknowledge; bonding social capital can facilitate social cohesion but can also reinforce social division, ‘you have to associate with your own kind’ (Male, Southern Alberta).
Putnam (2000) implies that bonded relationships are smooth and trouble-free. However, data from the current study indicates that tension is not uncommon. On numerous occasions participants highlighted conflicts:

‘there are a couple of members that I have trouble getting along with […] I just don’t stay around for very long’ (Female, Southern Alberta).

and tensions:

‘you also have to be careful about what you’re saying…that other people don’t try and copy what you’re saying’ (Female, Northern Highland).

Evidence of conflict between members of mental health voluntary organisations is not unique to the current study. Findings from Burns et al. (2002a, p. 14) highlighted the way in which rural mental health drop-ins can sometimes be perceived as unsafe, or even dangerous, by members particularly in relation to substance abuse. Specifically, some members were found to use the drop-in whilst under the influence of alcohol (which was challenging for others who were attempting to abstain from it).

One role of the voluntary organisations, however, appears to be to teach members how to manage and resolve conflict:

‘I tend to be very opinionated [but the manager] she’ll help me to see the grey areas’ (Female, Southern Alberta).

Being able to learn such skills is important, not only for personal growth but in knowing how to cope with similar situations outwith the organisation (transferability) (Lazarus & Folkman 1987).

7.2.5 Sub-Theme 1E) Collective Action and Social Citizenship

The idea of having a psychological sense of community involves an emotional connection with other members, underpinned by the idea that one’s needs can be met within that particular community (Boyd et al., 2008). In the context of bonding social capital, having a collective identity and a sense of belonging encourages reciprocity amongst members; feeling cared for encourages members to give and receive resources (Pretty et al., 2003), ‘[we help each other] it’s a two-way street’ (Male, Northern Alberta). Closely linked to this is the idea that social capital can facilitate collective action (Putnam 1995a; Ostrom & Ahn 2007), which taps into a deeper theme around
For Putnam, the relationship between political participation and active civic communities formed an essential aspect to his earlier thinking on social capital. For example, in *Making Democracy Work* (Putman, 1993a), political participation in Italy was linked with the successful accumulation of social capital. Regions with high levels of civic participation, civic identity and embedded cultural traditions (which can be considered as ‘stocks’ of social capital) experienced more responsive political institutions than those without, essentially demonstrating the powerful affect of social context on institutional performance.

The concept of citizenship is salient within the context of rural mental health voluntary organisations and social inclusion. Citizenship has traditionally been framed within a political paradigm but contemporary discussions on citizenship reflect a more nuanced understanding of this concept by paying greater attention to the socio-cultural dimensions within which citizenship can be invoked (Painter & Philo 1995; Mitchell 2009; Carens 2000). Whilst citizenship may offer one way of thinking about the relationship between the individual and the state (and the entitlements conferred by such a status), it is also about a category of belonging (Lewis 1998). Citizenship binds people with a common interest together and promotes harmony among them. It provides a means of ‘constructing a ‘we’…a group or collectivity bounded by place, status and interest’ (Lewis 1998, p. 104). In terms of the current study, the emphasis that voluntary organisations place on inclusion; of members feeling part of a community, of the positive and empowered self-identity members can construct through being part of that community, their obligations to other members, of being helped to find employment and good housing potentially offers a site within which members can materialise their citizenship:

‘if you think of [our organisation] as a voice for the [mental health] community and one of the parts of that voice is to promote respect, equality, acceptance and understanding, the only way we can do that is by all regarding each other as equal’ (Male, Lower Highland).

The framework within which such organisations operate offers a reconceptualization of the mental patient status to one of valued and important community member (Parr 2008). That the individual with mental health issues is a valued citizen is explicit in the ‘Clubhouse’ model, espoused by two of the Canadian voluntary organisations represented in this study. The fundamental aspects of this model of psychosocial rehabilitation are
that participants are considered ‘members’ that have an essential contribution to make to
the overall running of the program. As the founder of the Clubhouse model, John Beard,
notes:

‘All members are made to feel, on a daily basis, that their presence
is expected, that someone actually anticipates their coming to the
program each morning and that their coming makes a difference to
someone, indeed to everyone, in the program’ (Beard et al., 1982,
p. 47).

This inclusive community citizenship not only ensures members have opportunities to
take part in decision making, but that they can achieve their rights in respect to their
social status by securing employment and adequate housing. Marshall’s seminal essay
*Citizenship and Social Class* (1964) identifies work and welfare as an important route
through which a person can realise their social citizenship.

The dynamic nature of voluntary organisations (Parr et al., 2004), provides a space within
which there are opportunities for participation as citizens of a mental health community
with common interests. Such environments promote an empowered citizenship: ‘*they* allow a nonpathologizing community discourse that is less susceptible to judgment and
fosters expressions of power and collective social action...These actions serve to
counteract the stigma imposed by society and internalized by individuals while instilling
meaning in life pursuits’ (Onken et al. 2007). In this way, being a responsible member of
a meaningful community (the voluntary organisation), fulfils citizenship principles of
equal rights, obligations and opportunities. On a human level, it also fulfils the desire to
feel included and needed as demonstrated in the participant voices highlighted in
previous chapters.

### 7.3 Theme 2: Connecting outside the group: benefits/role

The following theme (Theme 2) focuses on the benefits and role of the voluntary groups
in relation to bridging social capital. A key distinction between bonding and bridging
social capital is that bonding social capital allows people to ‘get by’, whilst bridging
social capital allows people to ‘get on’ (Stone 2003). The latter allows people to draw on
resources so that they can interact and engage with a diverse range of people and
organisations that would usually be more distant. For example, community youth
programs bring young people together from both poor and affluent backgrounds, getting
them involved in various community projects that potentially connect them with other people and organisations through, for example, fundraising. Given its ability to sustain a diversity of relationships, bridging social capital promotes generalised reciprocity and trust beyond those who are familiar (National Council for Voluntary Organisations 2003, p. 7) or, as Putnam proposes, ‘bridging social capital can generate broader identities and reciprocity, whereas bonding social capital bolsters our narrow selves’ (Putnam 2000, p. 23). In lay terms, this can be interpreted as, for example, a local church. Not only does the church bring diverse people together in worship, it can create a sense of local (civic) identity. In addition, it can create referral networks that provide opportunities or support for parishioners (reciprocity), whilst also encouraging greater civic participation through the many community projects it may be involved in (Putnam 1993b). Membership to civic associations\(^\text{31}\) such as a voluntary organisation can offer an access point so that individuals can be involved in society and meet each other, thereby facilitating an identification with a civic collective at a local level, or, in other words, local civic identity (McKenzie 2006, p. 31). Theme Two presents the following Sub-Themes: 2A) Links outside the group; 2B) Cross-Membership; 2C) How external links reduce stigma and encourage civic engagement; 2D) Civic Engagement.

### 7.3.1 Sub-Theme 2A) Links outside the group

In both countries the voluntary organisations had forged strong links with local community mental health teams. These established links meant that potential members could learn about the voluntary group, thereby broadening opportunities for inclusion and participation (Stone 2003) and, on the other hand, established members of the group could benefit from more collaborative and joined up care:

‘if I’m having a problem here and [the manager is] aware of it, she’ll call mental health and talk to my worker’ (Female, Southern Alberta).

‘[the mental health clinic] bring clients over and they’ll get a tour of the place to see how they feel’ (Female, Northern Alberta).

For Putnam (2000), the core idea of bridging social capital is that it is outward looking and encompasses people across diverse social cleavages. It can, therefore, foster norms

\(^{31}\) Civic associations are generally considered organisations that are comprised of volunteers who provide a service(s) to the local community. However, voluntary organisations can be considered civic organisations because they are serving a public benefit that is not about the accumulation of profit (Eliasoph 2009)
of generalized reciprocity which, in turn, reinforce sentiments of social trust (Cullen & Whiteford 2001). The fact that it involves connecting with other individuals/organisations also means that it is better for linking to external assets and for information diffusion, essentially demonstrating positive externalities. In the context of rurality, opportunities to bridge with others is arguably even more important: greater distances, dispersed populations, extended travel times and the associated travel issues that characterise rural communities can often limit the development of social links and networks (National Council for Voluntary Organisations 2003). Within this study, these positive externalities were demonstrated in a variety of ways. For example, participants described feeling encouraged to connect with other people/agencies as a direct result of being involved with the organisation:

‘[because of coming here] I’ve [started] going a lot to the Players Club for coffee […..] I’ve even been doing little bits of work for them […..] if it weren’t for that, I probably wouldn’t be in this position because I can’t find the right kind of work in this town…because of my learning disability’ (Male, Northern Alberta).

In some cases they were inspired to tell others about the group, even suggesting that they visit and have a tour of the facility:

‘if I see someone that’s struggling [… ] I will suggest it to them…to come here and check it out’ (Female, Southern Alberta).

In this way, constant efforts at bridging ensured opportunities for participation (for existing service users), whilst potentially ameliorating the potential social exclusion of those who may be in need of, but were not yet accessing, mental health support.

Nevertheless, a key finding from the research was the way in which the Canadian organisations were discussed in much more proactive terms than their Highland counterparts, doing more to connect themselves with the rest of the community than the Highland organisations. For example, one of the Canadian organisations had forged links with the editor of the local newspaper, in order to raise their profile:

‘the editor of our local weekly newspaper […] is very supportive of who we are and what we do’ (Female, Southern Alberta).

In another Canadian organisation, various events had been organised that encouraged members of the public to take part:
‘Not to mention all the times that [the organisation] and the clients have put on the Christmas and Easter suppers….and it brings outside people in as well’ (Male, Northern Alberta).

The data reveal that service users are conscious of the underlying reasons for taking part in community events, that it was not simply about raising funds for the organisation but also about raising their profile:

‘we do things that put us in the public eye, like our chilli cook off every year……and once a year they have a big celebration in the park, and we run the concessions bit’ (Female, Southern Alberta).

One group also organised regular ‘appreciation dinners’ designed to encourage those connected with members (such as employers) to understand more about the person within the context of ‘service user’. In this way, holding events either at the voluntary organisation or taking part in events within the local community was about forging and maintaining social links:

‘we had an event two weeks ago, we had an ‘appreciation dinner’ […] and I invited my bosses […] that way they could see the two sides of me […] because I’ve told them that I do have a mental illness but I also have a life […] by coming here they can see that’ (Female, Southern Alberta).

As previously mentioned, two of the voluntary organisations in Canada were part of the international ‘Clubhouse’ model. Within this model, individuals that have been disabled by mental illness are helped to lead ‘vocationally productive and socially satisfying lives’ through the provision of ‘realistic alternatives to inadequate housing, chronic unemployment, long term hospitalisation and social isolation’ (Edward 1994, p.140). The work-orientated philosophy that is intrinsic to the model guarantees work placements for all as part of the ‘social contract it makes with members’ (Beard et al., 1982, p. 48). Within this vocational model, work performed by members within the organisation (voluntary) and externally (as paid employment) is a cornerstone of the organisation’s mission. In terms of work carried out within the organisation (referred to as the work-ordered day), members worked side-by-side with staff to carry out various tasks associated with a particular ‘work unit’, such as administration or food preparation (Macias et al., 1999); essentially helping to promote the idea that the contribution of members was vital for the continued running of the organisation. In relation to paid work, Transitional Employment Placements (TEP) gave members the opportunity to
work within mainstream community businesses (for a wage) as a way to improve marketable skills and learn social skills in preparation for eventual competitive employment (Macias et al., 1999):

‘there is the restaurant next door and it’s associated with working…so anybody that needs to get back into the swing of working…they can get a job there…..and it puts them back into the way of working’ (Male, Northern Alberta).

TEPs therefore provided members with the opportunity to work in mainstream settings which they may not necessarily have had, essentially ‘bridging’ service users with the rest of the community.

The subject of employment within the context of mental health is important. As previously highlighted, people with mental health problems are less likely to be employed than any other group of disabled people (Institute for Research and Innovation in Social Services 2012) despite the benefits of structure and routine for service users (Swarbrick 2012). It offers an important way through which an individual can be linked with society (Repper & Perkins 2003). The importance of work is reflected by the fact that it has been a central feature of the government’s social inclusion agenda (see p. 20). Avenues through which employment can be realised for service users are therefore highly salient. Within the context of social capital, opportunities for becoming part of workplace-based networks can provide a number of benefits. It can provide opportunities for building trusting relationships based on mutual assistance (BetterTogether 2000), which in turn can create a valuable source of information (e.g. help with problem solving or informal job contacts). Opportunities to establish friendships can also create ‘repeated…multistranded networks’ (Putnam 2000, p. 22) wherein colleagues not only connect with each other in work, but also meet each other regularly outside of work. In terms of bridging social capital, the workplace is the point through which diverse people can meet: ‘It is on the job that one is most likely to encounter, and work closely with, someone of a different race, ethnicity, religious affiliation, sexual orientation, social class, political ideology, or regional heritage’ (BetterTogether 2000, p. 12). In this way it can help to build a vocational community with others from across diverse social cleavages.

Nevertheless, as highlighted in Chapter Four, employment in the context of social inclusion is complex and arguably reflects wider neo-liberal concerns with promoting personal responsibility. In particular, the policy of social inclusion tends to present paid
work as the ideal of social life which essentially ignores the many problems associated with employment under contemporary capitalism, such as low pay. In the context of mental health, it can potentially be about providing positions that no one else wants or that are ‘hard to fill’ (Repper & Perkins 2003, p. 134). However, based on participant responses, opportunities to take part in TEPs were voluntary with no obligations (or benefit sanctions) if they did not want to.

The above discussion highlights the way in which the Canadian voluntary groups were far more proactive in terms of bridging with the rest of the community. One possible explanation for this difference could be related to culture. As noted in Chapter Four, from an historical perspective, the sheer land mass of Canada coupled with harsh winter conditions essentially forced rural people to develop support networks in order to survive. Whilst rural communities in contemporary Canada are far better equipped to deal with diverse weather conditions and geographic isolation, the distances between settlements suggest that there may still be a collective disposition towards forging links with others. Furthermore, the prevailing emphasis by government on social cohesion, national identity and national values (Bannerman 2011) offers some understanding for this community orientation.

7.3.2 Sub-Theme 2B) Cross-Membership

A key dimension of bridging social capital is that it enables members of one group to access the resources of another group (Woolcock & Narayan 2000). Data centred on this sub-theme reveals the way in which member involvement in a number of community networks enhanced their opportunities to mobilise resources. This was highlighted by one group in Highland, who shared their building with another community organisation (that was mental health related):

‘we were needing [new] premises, so we [spoke to a guy who worked here] and [...] he came back to us and said yes we could use it [...] we feel highly honoured that we’ve been given a key to a building like this you know’ (Male, Northern Highland).

In this example, the sharing of facilities was brought about by the participant having access to both networks. Whilst in this instance it benefitted the other organisation (i.e. giving them much needed facilities), inter-agency good will and recognition of shared aims (i.e. providing support) also encouraged mutual trust (Schneider 2009). Sharing resources in this way also created unforeseen benefits in relation to stigma. For example,
sharing the same building allowed members of each network to meet and become familiar with one another:

‘when we first [shared the building] two or three of our members wouldn’t come down and if they did come down, they’d make sure nobody seen them coming in…but after a couple of years, it sort of disappeared. Today […] they don’t mind people seeing them […] We’re so close with them that the sign on the door is not there anymore’ (Male, Northern Highland).

Whilst initially this was uncomfortable for members of the other organisation, familiarity and social contact meant that barriers created by negative feelings (e.g. wanting to stay distant from mental health) slowly gave way to a realistic appraisal and a friendlier outlook regarding service users.

Cross-organisation membership can also be an important resource in terms of exchanging ideas and information (National Council for Voluntary Organisations 2003). Several participants noted the way in which they were able to discuss the subject of mental health within the other networks to which they belonged:

‘I’m able to tell other people about mental health issues […] I also volunteer outside of the Clubhouse. I volunteer with a youth group’ (Female, Southern Alberta).

In some instances, members had encouraged non-members to tour the facility:

‘I’m trying to get people down at the [Canadian] Legion to come and get a tour of the place here’ (Male, Southern Alberta).

One participant spoke about the way in which he was able to refer various strangers on to the other network that he belonged to:

‘I’ve been lucky enough to be here through the day [and] four people [have] come in and approached [the manager] about alcohol problems […] I’ve [talked to them] and out of the four, there’s been two success stories […] They didn’t realise [the other organisation] was actually in here’ (Male, Northern Highland).

Belonging to several networks had facilitated information diffusion that had allowed others to access the appropriate service in a more timely fashion than might have been the case without these informal connections/social bridging.
7.3.3 Sub-Theme 2C) How external links reduce stigma and encourage civic engagement

As previously highlighted, there is a lack of research into social capital and mental health (McKenzie *et al*., 2002), making the contributions from this chapter particularly useful in understanding the link between the two. The discussion so far has highlighted numerous examples of the way in which rural mental health voluntary organisations contribute to social capital, both for members (i.e. encouraging a sense of belonging leading to good mental health outcomes) and in terms of local community life (i.e. taking part in community events and forging links with other community agencies). A further dimension is highlighted in this section: the way in which the external links created by the voluntary groups can reduce stigma and encourage civic engagement.

Data from the current study shows that social capital has a specific contribution in terms of helping to ameliorate stigma. For example, in Highland, participants of one focus group described a furniture project that allowed the community to donate unwanted items and/or buy as they needed. The scheme allowed both service users and community members to buy furniture at a price that they could afford. Whilst this provided economic benefits, it also provided opportunities for service users to engage with the wider community. In terms of stigma, not only did this provide opportunities for interaction that reduced the social distance between the two groups, it also potentially helped to change negative attitudes to mental health. The project had also acted as an information point which had led to members of the public accessing the service for mental health support. In Canada, bridging with the rest of the community, essentially being visible, was also found to act as a conduit for information diffusion:

‘We did something before…..we set up a booth for something […..] and more and more people [were] walking by and saying, ‘well I’m really stressed and I need to talk to someone’….we’ve given them names for people to call, psychologists and so on’ (Male, Northern Alberta).

Such examples serve to highlight the importance of social interaction, not only as a way to reduce the distance with the wider community, but also in helping to break down stigma.

Opportunities to engage with the unknown ‘other’ can, therefore, potentially disrupt stigma processes. As Goffman notes, ‘although impersonal contacts between strangers
are particularly subject to stereotypical responses, as persons come to be on closer terms with each other this categoric approach recedes and gradually sympathy, understanding, and a realistic assessment of personal qualities take its place’ (Goffman 1963, p. 68). The data reveal that participants are aware of the need to be visible and to have contact with the rest of the community, in order to demystify any negative assumptions:

‘The community here, I think they really respect us….they don’t see us as a bunch of weirdos because […] we’re out in the community taking action and doing things’ (Male, Northern Alberta).

The idea that social contact and familiarity can potentially decrease prejudiced attitudes is widely recognised (e.g. Corrigan & Penn 1999; Reinke et al., 2004; Anagnostopoulos & Hantzi 2011). Evidence suggests that individuals who are familiar with mental illness (either directly or indirectly) are less likely to endorse prejudicial attitudes (Holmes et al., 1999; Corrigan et al., 2002). Stigma is further diminished when members of the general public meet persons with mental illness who are able to hold down jobs or live as good neighbours in the community (Corrigan & Watson 2002). This familiarity was highlighted by one Highland participant as she described the way in which her previous neighbours helped and assisted her with everyday things when she was unwell but employed:

‘my [previous] neighbours were great then, even though occasionally I had problems but I was working then. I was a successful member of society if you know what I mean. They use to put my bin out every week for me, the guy use to cut my grass, they showed me how to light the coal fire’ (Female, Northern Highland).

Within the context of social inclusion, opportunities that allow interactions between people with mental health problems and wider society are therefore important. As previously noted, social exclusion has a transactional aspect (see Figure 1, Chapter 2) fundamentally linked to unequal power: the excluded and the perpetrators of exclusion. In the context of power differentials, social capital can create opportunities for individuals and organisations to have shared aims, thereby creating spaces where people can come together on an equal footing.

This powerful potential of social capital was highlighted by one organisation in Highland. The organisation was involved in breaking down barriers and connecting with others through workshops, training and consultancy work:
‘[we provide] mental health awareness training [...] letting them learn from our point of view what it’s like to go through what we go through [...]. By doing that, they can ask us all sorts of questions they never dared ask, and in that sort of safe environment they can shift attitudes without having to acknowledge that they are shifting them, or learn how to be with us in ways where they don’t worry that they are going to say the wrong thing or do the wrong thing’ (Male, Lower Highland).

In this example, the power differential shifted. Instead of comprising an excluder and an excluded, it was situated between those who know about the reality of mental illness and those who wish to know. Additionally, the premise that people can ask questions and seek advice about the reality of living with mental illness highlights that they trust and respect the service users they are asking (Schneider 2009). Also, the idea that people can ‘shift attitudes without having to acknowledge that they are shifting them’ suggests that holding prejudiced attitudes about mental illness may, for some, simply be about a lack of education about mental illness rather than any deep rooted stereotypical belief (Corrigan & Penn 1999).

In terms of comparisons between Highland and Canada, findings from this section suggest much similarity in terms of the desire to bridge the distance between the two communities (i.e. service user and mainstream) as a way to lower barriers and to change any negative assumptions that people may hold about mental health. For Canadian organisations, this was achieved by participating in local community events, whereas for Highland participants, this was achieved through raising awareness about mental health.

7.3.4 Sub-Theme 2D) Civic Engagement

The second impact noted in terms of links outside the voluntary groups was in relation to civic engagement. The following section focuses on the way in which social capital, via voluntary group membership, had revitalised an interest in political engagement for some members.

In Putnam’s *Bowling Alone* (2000) civic engagement was captured in terms of political participation, such as voting, working for political organisations, discussing politics with neighbours and signing petitions. In terms of social dimensions, the way in which people connect with their communities was represented formally by participation in various civic organisations such as voluntary associations or church-based groups, and in work through organisations such as worker unions. Informal civic engagement was captured in terms
of gossiping with neighbours, sharing a barbeque picnic in the summer or even nodding to another regular jogger on the same daily route. Data presented earlier in this chapter reveal the way in which the rural voluntary organisations facilitate these multiple forms of civic engagement, from taking part in local community events, to TEPs that prepare members for competitive employment.

In Highland, the more formal dimension of civic engagement (political participation) was captured in one focus group, where the organisation was active in training and consultancy work (see ‘Site B’ p, 94). As part of their remit, the organisation would take part in government consultation processes and would produce reports that captured the ‘voice’ of service users:

‘we have these discussions and then [the manager] turns them into absolute master pieces […] and that is empowering because we send these reports to people who we wish to influence, like the police and so on’ (Male, Lower Highland).

Producing reports was found to have far reaching consequences in terms of influencing those at the highest political levels:

‘because of [our] reports [the manager] has been asked to speak to the people that matter and make the decisions all over the country’ (Male, Lower Highland).

Part of their mental health training delivery involved asking members to stand up and talk about their personal experience of mental illness to various organisations and professionals. From a social capital lens, it can be seen that taking part in public talking demonstrates the ‘public and private faces of social capital’ (Putnam 2001, p. 1). In terms of the public return to social capital, the provision of mental health training and publication of reports by those with lived experience of mental illness helped to raise awareness and increase understanding amongst the public. In terms of the private returns to social capital, being able to stand up and talk openly to strangers about the personal impact of living with mental illness not only requires courage but also requires the person to become vulnerable by talking about deeply personal, and sometimes difficult, issues amongst people they do not know. In the long term, however, engaging in this way can be empowering and liberating (Matthew 2001).

The notion that membership of civic institutes encourages political participation is an important point in the context of social exclusion/inclusion. A higher level of political participation can ensure government policies are more responsive to the needs of the most
disadvantaged in society (Kawachi 2006). For one participant, membership to the voluntary group had facilitated participation in other mental health awareness campaigns:

‘The Citizens Advice Bureau had a special section to help people with mental health problems and [the manager] asked me to speak’ (Male, Lower Highland).

Involvement with raising awareness about mental health issues had also extended beyond national boundaries:

‘[this organisation] has an international reputation because of the work [the manager] has done abroad. I’m on the Board of [another organisation] and they sent me to Denmark and the last day was [about] highlighting organisations and [this organisation] was specifically mentioned’ (Male, Lower Highland).

In this way, social capital had empowered members and revitalised interest in political engagement, essentially providing a way of increasing the commitment to participative democratic processes (Social Care Institute for Excellence 2007, p. 3).

7.4 Theme 3: Building Social Trust

This final theme focuses on social trust as it is central to Putman’s thesis on social capital (Putman 1993a, 2000, 2007). He notes, ‘a society that relies on generalized reciprocity is more efficient than a distrustful society, for the same reason that money is more efficient than barter. Trust lubricates social life.’ (Putnam 2000, p. 21). Establishing trust becomes an important means through which reciprocity can be achieved.

There were numerous examples of the way in which the voluntary organisations had facilitated a more trusting disposition in members. In one example, the participant related this trust in terms of other members within the organisation:

‘we use an honour role here as far as the tuck shop goes... that’s how we look at this whole [organisation].....on the honour role system.....and it’s helped me to trust more’ (Male, Southern Alberta).

Trust was also encouraged between members, mediated by the notion that ‘whatever happens in here, stays in here’ (Male, Western Highland). Establishing trusting relationships with staff was also considered a crucial element to membership:

‘I know myself that I could trust any member of staff with anything that’s bothering me’ (Male, Northern Highland).
In the context of mental health and social inclusion, the notion of building social trust is important. It is well evidenced that service users regularly experience stigma on the basis of their mental health problems (see Chapter 4). In a rural context, where there is shared knowledge about inhabitants, being perceived as different can be challenging and can lead to isolation and even hostility from other community members (Watkins & Jacoby 2007). Learning to trust is therefore important.

Nevertheless, in-group solidarity has the potential to produce a ‘narrow radius of trust’ (Fukuyama 2001) in which group members are inclined to become insular and only trust those they are connected to. In some cases this can reduce the ability of members to cooperate with outsiders (negative externalities). It is therefore important that there are positive externalities. In one group, the public return to social capital was captured as one participant described the way that she had been inspired to become more involved with other tenants in her block where she lived:

‘I think I’m going to get a lot more involved with the other tenants […] and it’s because I’ve gotten the confidence from coming here’ (Female, Southern Alberta).

In this example, membership to the voluntary group had facilitated a more trusting outlook in terms of how she related with others in the wider environment. Whilst such informal connections may not represent any formal civic engagement, such connections, no matter how brief or infrequent, are important for sustaining social networks and for generating reciprocity, or as Putnam would say ‘like pennies dropped in a cookie jar, each of these encounters is a tiny investment in social capital’ (Putnam 2000, p. 93). The more individuals connect with one another, the more they trust them. In this way, social trust and civic engagement are strongly correlated (Putnam 1995b). From an historical perspective it is arguable that social and economic change has lessened opportunities for building trusting relationships with other community members. Industrial change has effectively destroyed old mass manufacturing and associated communities with their characteristic social and political organisations (churches, union branches, etc.). The working class organisations that once provided mutual support within local communities have been stripped away by such economic and social change. In rural areas, agriculture and other rural activities have largely ceased to be the business of whole communities, putting farmers as the highest ‘at risk’ group in terms of suicide (Stark et al., 2006). Such isolation can, therefore, disrupt social cohesion by limiting people’s participation in civic life, essentially depriving them of the touchstones of reality available through informal social interaction, shared aims and activities.
Data from this study also revealed that developing trust can encourage innovative ideas. One participant in Highland described his initial unease with joining the organisation due to his fear of crowds and his tendency to be reclusive. Nevertheless, gradual familiarity with others inspired him to suggest new ideas for mental health service user engagement in the community linked with conservation work:

‘I spoke to somebody about a possible idea which is now a reality, about starting up another service [...] called the Green Gym [...] using exercise as a way to improve mental health and community involvement’ (Male, West Highland).

In this example, being part of a mental health network had facilitated the development of trust and provided the means through which his innovate thinking could be made manifest in reality.

7.5 Chapter Summary

Social capital refers to social networks and the norms of reciprocity and trustworthiness that arise from them: its essential message is that social connections have value. Bonding capital can foster a strong sense of connection and group loyalty, whilst bridging social capital can increase opportunities for participation. These concepts provide a useful lens for interpreting and understanding the benefits and the role that rural mental health voluntary organisations play for their members and for the communities in which they are located.

Bonding capital, the sense of loyalty and solidarity that members felt, demonstrated powerful social effects. As per Cohen and Wills (1985) model, being part of a close-knit network was an important resource that provided members with emotional and practical support, encouraging better help-seeking behaviour and overall stability. In this way, positive health messages were easier to promote (McKenzie 2006, p. 31). As the data demonstrates, being part of a group ‘bounded by place, status and interest’ (Lewis 1998, p. 104) offered a local, contextualised place where citizenship could be practiced (Perron et al., 2010). Moreover, being part of a community of likeminded individuals highlighted the possibility of thinking more critically about notions of citizenship that move away from traditional political conceptions. Reconfiguring citizenship in this way is particularly important for a population that has often been denied civic and legal rights due to their mental patient status (Sayce 2000).
The data also highlight the many ways in which rural voluntary organisations connect with other individuals and organisations in the community, thereby demonstrating bridging social capital. Whilst bonding social capital is important, bridging is arguably more so given that it provides opportunities for the mental health population to link with mainstream society. Within the study there were numerous examples of such links. It was also clear that Highland and Canada differed substantially in terms of bridging social capital. Most obviously, Canadian rural voluntary organisations were far more active in terms of creating such links, both formally (e.g. Transitional Employment Placements) and informally (e.g. local community events). Possible explanations underpinning these differences are connected here with Canadian culture and a prevailing collective disposition linked historically with the challenges of living in such isolated environments.

The study also demonstrates the powerful impact of bridging social capital in relation to stigma. In particular, opportunities for service users to interact with the non-mental health population was found to be an important way to reduce the social distance between the two groups. As the data show, not only can this be important in terms of education (mental health awareness) but also in terms of addressing power differentials between the two groups. Facilitating such opportunities is particularly important in rural communities, where attitudes to mental health service users can often be more unforgiving and entrenched than in more urban environments (see Chapter 4).

Finally, ties that link members with each other and with the rest of the community facilitate social trust. For Putnam, trust is a means through which reciprocity can be established, ultimately helping to build socially cohesive communities. Within the study, establishing trust and reciprocity was evident by one voluntary organisation in Highland that shared their facilities with another community health group. Sharing facilities in this way, not only provided a way for an efficient use of resources (lubricating social life) but also helped to encourage a sense that the favour would be returned in the future (generalised reciprocity). On an individual level, a trusting disposition also inspired some to establish links with others outside of the voluntary organisation. For a population that has often been rejected and discriminated against, building trust is therefore crucial. Such findings raise the profile of rural voluntary organisations and demonstrate the way in which they play a key role in terms of their contributions to members and also in terms of their contributions to local community life.
CHAPTER 8

CONCLUSIONS: RURAL MENTAL HEALTH POLICY AND PRACTICE
8.1 Concluding the Thesis

The overarching rationale for this thesis was to contribute to the knowledge base on rural mental health using the theoretical basis of social inclusion. The specific research aims were to explore the impact of rural life for mental health service users’ daily life and access of services (aim 1), and to understand the contribution of rural mental health services to tackling social exclusion for service users. The key objective was to capture the voices of rural service users (and providers) in order to contribute to and expand the knowledge base.

This thesis illustrates that rurality has a significant role to play in shaping the experiences of mental health service users. In particular, rural culture shapes negative perceptions of mental health, leading to stigmatising attitudes by local community members (this was found to be more pronounced in Highland than Canada). However, rural places were also conceived as positive places in which to live as a service user despite limited mental health support. Rural professionals aimed to be adaptable in how they delivered their services (to account for stigma) but were limited by a number of logistical and financial constraints that impacted on the level of care they could provide.

Whilst the policy drive to close the large scale asylums arose from concerns about the denial of rights and freedoms for the inhabitants, and the generally bad conditions of those institutions, for service users, community care has been ‘the most chequered and ambiguous of policies’ due to inadequate implementation and under-resourcing; negatively impacting both on public perceptions of madness and distress, and on how service users see themselves (Beresford 1998). This was succinctly highlighted in a recent headline by a national newspaper, stating that 1,200 people have been murdered by mental patients (Morse 2013). Whilst this potentially exacerbates public perceptions of madness (i.e. stigma) it raises the element of public risk given the inadequacy of provision in community care. The on-going evidence of stigma and social exclusion faced by users of mental health services suggests that institutionalised and segregated life in an asylum setting has only been replaced by social isolation in a community setting. Within this context, therefore, the policy of social inclusion has been a central feature of the community mental health landscape. However, the concept of social inclusion has continued to spark debate as to its fundamental meaning. Furthermore, and perhaps surprisingly, despite moving the loci of care from the asylum to the community some decades ago, a paucity of studies have examined mental health in a rural setting. This work offers an important contribution to the existing knowledge base by contextualising
the experience of mental health in rural community settings within a social inclusion
conceptual framework (see Chapter 3 for working definition).

Given the emphasis on ‘care in the community’ the programme of work has also sought
to understand the contribution of rural mental health voluntary organisations, of which
knowledge is limited despite their key role in community-based mental health care
(Milligan 2000). Additionally, there is increasing pressure on voluntary organisations
given the current economic climate and on-going cutback to public health services (UK
Civil Society Almanac 2012). Research that explores these factors is therefore timely.
This study adds to existing knowledge by applying the concept of social capital (Putnam
2000) in relation to rural mental health voluntary organisations. In the policy landscape,
the concept of social capital has been used as a way of reducing the incidence of mental
illness by promoting a sense of community and belonging. Nevertheless, as per social
inclusion, the general literature on social capital remains contested and divided, possibly
due to its application within the field of mental health being in its infancy (De Silva 2005;
McKenzie 2006). The current thesis, therefore, adds to the current knowledge base by
empirically demonstrating the role social capital plays in connecting members of mental
health voluntary organisations to each other and their respective communities.

This programme of work has sought to explore these key concepts in order to advance
knowledge of the experience of mental health in rural environments. In particular, the
research sought to understand what it means to experience mental health problems in
remote and rural areas (Research Question 1) and what some of the challenges were for
mental health professionals practicing in rural areas (Research Question 2). The research
also sought to understand the contribution of mental health voluntary groups in terms of
community-based care (Research Questions 3 and 4). Finally, the concept of social
capital was used to explore the contributions of voluntary organisations (Research
Question 5).

The following sections of this chapter bring together the main empirical findings in
relation to each research question. Firstly, the complexity of experiencing mental health
problems in remote and rural areas is presented. The chapter then brings together the
main theoretical and policy implications in relation to service providers by firstly
considering recovery and then social capital. In bringing the main findings and policy
implications together, the chapter will present key directions for future research before
finally exploring the strengths and weaknesses of the study. The chapter includes a reflexive statement from the researcher before closing with some concluding remarks.

8.2 Empirical Findings

The main empirical findings are chapter specific and were summarized within Chapter Four through to Chapter Seven. The rest of this chapter synthesizes the empirical data and presents the theoretical and policy implications of the findings.

8.3 The complexity of experiencing mental health problems in remote and rural areas

The following section summarises the three themes that encapsulate the findings for the first thesis question.

**Theme 1: Stigma**

The findings from this research demonstrate that living in a rural area with a mental health problem can be a source of exclusion and inclusion. For example, the social proximity that is characteristic of rural living was found to be a source of comfort in terms of knowing who others were. Nevertheless, that same proximity served to reinforce boundaries around acceptable and unacceptable behaviour, around who was considered included and accepted, and who was not. In the literature, indicators of social inclusion are often measured in terms of employment, good housing, income and education, whilst these are also relevant in rural areas, this study has found that there are other specific rural factors that can compound the social exclusion of those who are considered ‘different’ due to their mental health identity. These would include a shared intimate knowledge of all community members who reside in that locality and the prevalence of efficient gossip networks. These made it difficult to maintain anonymity and confidentiality around mental health issues. Moreover, the decision to engage with mental health services had lifelong implications due to the ‘fixed’ service user identity ascribed by other community members.

This study identified that rural culture (taken here to mean aspects such as informal networks, self-reliance and social proximity) plays a significant part in shaping (mostly negative) perceptions of mental health and help-seeking behaviour. Much of the findings around the negative aspects of rural living, most notably stigma, were especially relevant
to Highland participants. As noted in the discussion (Chapter 4), possible explanations for this may be the role of religion and its influence in shaping the rural ‘way’ in the Highlands and the prominent role of alcohol consumption as a key aspect of social life (see also Burns et al., 2002b). Additionally, the Highland communities involved in the research were considerably older in origin, with social ties between residents spanning generations. By implication, this gives rise to more entrenched beliefs that shape attitudes to those who are different.

However, the assertion that stigma is worse in the Highlands is complex. For example, in contrast to Highland participants, all Canadian participants felt accepted in the community yet the wider literature on mental health stigma in Canada (see discussion on ‘Canadian Culture’, Chapter 4), and the study data from Canadian service providers, clearly suggest that stigma is a major issue. Interestingly, quantitative surveys that have explored aspects of Canadian citizenship, such as tolerating others who are different, found that this was lower in provinces such as Alberta compared to the other areas of Canada (Institute for Canadian Citizenship 2012). It may be that further qualitative investigations of rural mental health are required in order to explore more deeply what it means to experience a mental health problem in Canada and to unravel the complexity of everyday life for rural service users.

A further dimension to the problem of stigma was in relation to the media. For participants in both Highland and Canada, the media was the main mechanism through which fear and ignorance were perpetuated within mainstream society. Indeed, the previously mentioned headline that 1,200 people have been murdered by mental patients (Morse 2013) is a case in point. However, given the statistics that one in four will experience a mental health problem at some stage of life (MIND 2013) such headlines highlight the extent to which the problem appears to be swept under the carpet so that only the most dramatic cases are publicised and become typical of popular conceptions of the subject (Mental Health Foundation 2013b).

Nevertheless, there are lessons that can be learned from Canada. The Mental Health Commission of Canada (2013) has sought to break down stigma through its Opening Minds campaign. The campaign has included mental health presentations to journalism students as a way of raising awareness around the importance of responsible reporting. Evaluations of the program to date have shown that it can reduce stigma and promote positive attitudes towards those with mental health problems (Lillie et al., 2013). In Scotland, a number of educational initiatives have also been rolled out in order to raise
awareness about mental health (Scottish Government 2011c). Again, such efforts are crucial given the high levels of stigma noted throughout this study: the starting point has to be education so that community members can become more tolerant of mental health issues and those who experience it. Breaking down the stigma of mental health and encouraging people to talk about it can also increase help-seeking behaviour in rural areas.

**Theme 2: Complexity of Place**

A further finding from this study was that the drivers for migration differ across the two countries. This is an important theme given the limited knowledge on the subject (see Philo & Parr 2004). Both Highland and rural Alberta face considerable problems in terms of accessibility and availability in terms of mental health service provision and yet the reasons cited for moving by Canadian participants was generally focused on resources. For Highland participants, the reasons for moving were bound up with notions of a better life, or to escape the perceived claustrophobic nature of rural community life. Further research is required to identify what underlies this difference.

Whilst the myth of the ‘rural idyll’ has long since been challenged in academia, this study has shown that participants still construct the rural way of life in terms not dissimilar to such an idealised image. However, a key point of divergence here is that participants did not construct the rural in a way that was uninformed or naïve (Halfacree 1995), they were clearly aware of the limitations and some of the hardships associated with rural life, including their first-hand experience of stigma and discrimination, and the lack of choice in terms of mental health service provision. Such critical reflections, therefore, demonstrate that having a sense of belonging and affinity are important factors in terms of the everyday lives of rural service users (see Proshansky 1978). Further qualitative research is required to explore the nature of rural migration within the mental health community, to investigate in-depth the importance of place and its influence on cognitive dispositions and identity formation for service users.

**Theme 3: Service User Narratives**

Analysis of service user narratives revealed a disjuncture between the policy of social inclusion and the lived reality of mental illness for rural service users. The data revealed three key ways in which the rhetoric of social inclusion policy does not match the reality. Participants recounted, for example, deeply personal experiences of rejection and discrimination by others due to their mental health problems. However, far from feeling victimised, they were empowered to challenge discrimination and negative attitudes that
they came across in their everyday life; adversity had strengthened their own ideas of
who they were in relation to their service user identity.

A further dimension to this disjuncture was found in relation to the implicit assumptions
contained within the policy of social inclusion. Specifically, the policy operationalizes a
dichotomous model of society: the insiders as an included majority and the outsiders as
an excluded minority (Levitas 2004). Furthermore, a key feature of the policy is that it
advocates the importance of participation in mainstream settings. Yet this ideal of social
life was sometimes a source of anxiety for service users in this study due to the continual
rejection that they have faced by the ‘included majority’. Additionally, the strain of
trying to fit in was a further source of stress, again presenting a challenge to the
assumptions of what it means to be assimilated within mainstream society.

For the policy of social inclusion, labour market participation is recognised as a key
signifier of inclusion. However, the findings from this study have shown (see Chapters 6
and 7) that economic inactivity does not necessarily lead to exclusion from social
relations, raising questions around whether the social aspects of social exclusion are
actually at the centre of these debates (Levitas 2006). The promotion of labour market
participation as the primary means through which social contact and interaction can be
achieved, and as the basis of self-esteem, was challenged by participants on the grounds
that being productive was not simply about paid work. For a number of service users,
taking part in voluntary work, or feeling able to help others on their journey were the
sources through which abstract qualities of feeling included were achieved.

8.3.1 Policy implications in relation to mental health stigma and social inclusion
policy

Mental health stigma was a clear theme in relation to understanding the rural experience
of mental health, leaving questions as to why, despite considerable efforts to address this
issue, stigma remains a significant problem for users of mental health services. The
findings suggest greater attention needs to be paid to tackling stigma (i.e. through contact
based educational initiatives in line with Canada) in rural areas so that mental health is
something that can be openly discussed and talked about, rather than hidden or, in the
Highlands, masked by alcohol consumption. However, in order to advance the
knowledge base, robust evaluations are needed to investigate if, and what, impact such
types of education have on the audience in terms of altering behaviours or long-held beliefs.

In relation to the rhetoric-reality gap, critiques offered by Levitas (2001, 2004, 2006, 2007) demonstrate the importance of a continued focus on the concept of social inclusion given its ideological overtones. In the context of mental health, work by Spandler (2007) also cautions against the uncritical use of the social inclusion conceptual framework on the grounds that this can be used as a tool for moral and social regulation. Analysis of service user narratives in this study resonates with these arguments. If policy is to be responsive to need, there should be a utilisation of local knowledge to inform best-practice; and rural service users need to be consulted to a greater degree as to what they feel is important for their wellbeing and of where they feel ‘included’; given that such involvement is still considered an essentially minority activity (Tait & Lester 2005). Policy makers need to also be aware of the importance of mental health communities as sites of inclusion.

Finally, social inclusion policy presents paid employment as the primary means through which people can achieve a state of ‘inclusion’. In this way it undermines the legitimacy of non-employment (Levitas 2001). Findings from this study have shown that feeling productive can be achieved in alternative ways. This reflects other research findings (Parr 2005; Secker et al., 2009). If any employment policy is to be responsive to need (Tait & Lester 2005) then careful consideration needs to be given as to the best way to help service users into employment, or, at the very least, to ensure that they are not penalised should this not be the best way forward for them at that particular time.

8.4 The challenges facing rural mental health professionals

The findings from this study have shown that providing mental health services in rural areas presents unique challenges. Health services are inextricably linked with the viability of rural communities and current changes are liable to impact more significantly than in urban communities (Godden 2005 p.294). The views of those who are involved in rural health care are essential to policy and planning. The following section addresses the key themes that emerged from this study in relation to service providers perceptions and their theoretical and policy implications.
Theme 1: Rural Service Design

A key difference in terms of cross-national comparisons in this study centred on rural service design. For Canadian professionals, the provincial government designed services in a way that accommodated rural factors such as time, distance and small populations. In contrast, Highland professionals felt this was not the case. The data suggested that rural mental health professionals in Highland were under immense pressure in terms of being able to respond appropriately to those who required mental health support in the community (see Chapter 5). Moreover, as noted in Chapter Five for rural service users that are in crises, the time and distance dimensions of rural practice had led to significant delays in their transfer to appropriate settings (Remote and Rural Areas Resource Initiative 2003). Such factors need to be considered in greater detail given the accent on prevention in mental health policy; if the focus is on lower-level interventions, then rural services need to be designed in a way that supports professionals to achieve this.

Sub-theme 1A: On-going issues for delivering to First Nations people

However, whilst rural service design generally represented a point of divergence between professionals in each country, with Canada faring better, the issue of delivering services to First Nations people remains a problem in Canada. As highlighted in Chapter Three the long history of cultural oppression and marginalization has contributed to high levels of mental health problems, in particular suicide, amongst the Aboriginal population in comparison to the rest of the population (Isaak et al., 2010). Moreover, on-going socioeconomic inequities continue to exert a considerably negative influence in the context of First Nations mental health, making the legacy of colonialism something that has not fully been addressed and dealt with in modern day Canada. The data reflected previous findings - that the federal system of health care delivery for First Nations people currently resembles a ‘collage of public health programs with limited accountability, fragmented delivery and jurisdictional ambiguity’ (Reading & Wien 2009, p. 15) – but added that mental health professionals feared for their personal safety in First Nations reserves. However, there does seem to be a change detectable in terms of health planning in Alberta in the context of Aboriginal mental health. In particular, there is an increasing recognition of a holistic approach (i.e. incorporating physical, spiritual, emotional and mental dimensions) to service development and delivery (see Alberta Mental Health Board 2006), including more effective partnership working in order to support mental health needs. Such a direction is particularly important in terms of addressing the mental
and cultural needs of the Aboriginal population. However, this study has highlighted that there are still challenges which might impact on the level and quality of care.

**Theme 2: Recruitment and Retention**

The overlap between public and private life was a significant issue for professionals in this study. This is important in terms of service planning because it could potentially act as a deterrent for those considering working in rural areas. Reconciling this was found to be easier for those that had grown up in rural areas and generally felt more at ease in such settings, in line with previous research (Hegney *et al.*, 2002; Laven *et al.*, 2003; Richards *et al.*, 2005; Weller 2005). Practicing in rural areas can be challenging for professionals due to professional isolation and difficulty accessing training and development opportunities. There was a sense here that service planners did not recognise the needs of health professionals in Highland, instead running training events in centralised areas of Scotland. Addressing these issues is important to both support existing professionals and to attract mental health professionals to work in rural areas.

**Theme 3: Collaborative Rural Working**

This study also evidenced positive collaborative working between rural professionals within multi-disciplinary teams. The essential message was that rural professionals have to get along and pull together due to limited options. This offers an important insight into rural mental health service delivery. However, the pooling together of resources, sharing information, holistic working, and developing innovative strategies, may be a focus for improving working practices and conditions, and recruitment and retention in both Highland and Canada.

**Theme 4: Resources**

Whilst the above discussion points to the benefits of rural practice, service providers were also facing increasing pressures around resource constraints. In some instances, this had reduced the amount of time spent with clients and longer waiting lists in Highland. This is a major issue given the therapeutic value of time highlighted in Chapter Six and suggests that service users would benefit from greater investment in this aspect of service delivery. Greater investment needs to be targeted in this area rather than taken away. A further point here is that over-stretched professional services has resulted in compulsory hospitalization more frequently in Highland compared to other Health Boards (Mental Welfare Commission Scotland 2012). Whilst this is arguably about the limited
availability of backup services, and perhaps as a ‘fail safe’ policy against leaving a ‘dangerous’ patient at large, it has considerable civil liberties implications given that deprivation of liberty otherwise can only be justified on the strongest evidence in the course of criminal proceedings. This essentially reinforces the need for better resources for rural mental health professionals.

**Theme 5: Rural Voluntary Organisations**

The final section of Chapter Five focused on service provider perceptions of the voluntary sector. Their high regard for the sector was clear. There was a sense that the sector was increasingly relied upon given the wider cutbacks within the statutory sector. However, voluntary organisations were facing increasing competition from each other due to the economic climate. Those involved in rural policy and planning need to be aware of this tension so that the sector is given the funding it needs to cope with rising demand.

**8.4.1 Policy implications for rural mental health professionals**

The provision of health services to rural communities has involved a focused effort over the last two decades. In particular, it is recognised that issues such as access and equity of provision require special attention in rural communities (Weller 2005). However, as this study has shown, the training needs (including where the training is provided) of Highland professionals are not being met despite the evidence that on-going good quality training and education (including improved training pathways) is the most effective way of increasing professional capacity in rural areas (Scottish Government 2008). In terms of policy, greater emphasis should be placed on continuing professional development and professional support programmes (in line with Canada) in order to provide greater supervision and direction. As previously highlighted in Chapter Five, UHI has over 70 learning centres with Internet links located throughout the Highlands and Islands. In this way, there could be a cross-utilization of resources between different institutions for training purposes. However, any potential interventions need to have robust evaluations in place to assess their effectiveness.
8.5 Opportunities for recovery (Part 1)

Research question two of this thesis set out to understand the role and benefits for rural service users attending voluntary groups. The answer to this question is that rural voluntary groups promote recovery for members. These findings are particularly important given the limited empirical evidence available on recovery in the context of the rural voluntary sector (despite a considerable reliance on the sector in both Highland and Canada). The ways in which this occurred were grouped around three main themes. The following section summarises these themes and considers the theoretical and policy implications.

**Theme 1: Meaningful Engagement**

Findings from this study have shown that, for participants, being able to express themselves naturally, in a way that was not constrained by community attitudes and expectations, was a crucial component in why they attended voluntary organisations. This acceptance essentially allowed members to accommodate their experiences in order to move forward on their journey of recovery (Repper & Perkins 2003, p. 95). Feeling accepted through mutual understanding and respect was the mechanism through which members could move beyond the diagnostic label and be seen as a person with individual interests and abilities. This is a fundamental point in the context of recovery (Repper & Perkins 2003). In relation to rurality, such opportunities to engage with likeminded individuals, to move beyond the ‘patient’ identity is arguably even more important given the issues with rural culture previously highlighted (Chapter 4). The implication here is that these potential benefits could also be promoted to other rural service users (who are not currently engaged with services) to ensure they are informed about the benefits of membership to this type of organisation.

The voluntary organisations in the study provided a range of activities for members. In terms of recovery this not only offered the opportunity to socialise with others but also allowed for the expansion of valued social roles, again allowing members to explore identities that moved beyond that of patient (Onken et al., 2002). These instilled hope and increased the level of motivation that members had in terms of continuing to maintain contact with the organisations. Whilst this contributed to a healthier outlook and consequent behaviour for members, further research would be useful in order to explore more about motivation in terms of whether other factors can be attributed to the
process apart from membership of the voluntary groups and, also, what impact increased motivation has in other areas of members’ lives.

**Theme 2: Recognising Autonomy**

A further theme in the recovery literature relates to the importance of gaining control (Anthony 1993; Smith 2000; Ramon *et al.*, 2009). The findings from this study have shown that this is an important way in which voluntary organisations help members. In particular, staff at the organisations recognised and prioritised the personal autonomy and agency of each member, which facilitated a sense of self for members. Theoretical contribution by Davidson and Strauss (1992) was particularly helpful in breaking down how such an abstract notion of ‘sense of self’ could be actualized. Further research would be useful to explore this process further, to gain more understanding of whether the process is the same across all situations and for all mental disorders.

The ability for members to view themselves as capable of choosing, initiating and accomplishing things is central for self-management skills and for the attainment of valued social roles (Slade 2009a). Nevertheless, the idea of promoting personal responsibility has been a source of concern for some given that it could potentially be used to cutback services (Joint Position Paper 08 2007). The assertion from this study, however, is that the development of agency is a key recovery process that is integrally tied with social inclusion; the individual needs to be able to develop the skills and capabilities necessary to access the opportunities and move beyond the patient identity, conversely the opportunities need to be available in order for service users to reconstruct a sense of agency and consequently to participate in mainstream society: personal responsibility and social opportunity are the twin requirements for community integration (Slade 2009a). It is, therefore, about more efficient use and allocation of resources that are responsive to what *service users* want and that enable choice.

**Theme 3: Supportive Relationships**

Within the mental health literature, the importance of relationships is recognised as a key aspect for recovery and for enhancing social inclusion. The findings from this study show that supportive relationships, based on respect and mutual responsibility, were an important component of healing and for providing emotional insight. This may be a
particularly important role for voluntary organisations in remote and rural areas, where opportunities are limited in terms of forging friendships and meaningful relationships.\textsuperscript{32}

8.5.1 Voluntary organisations as distinct from other mental health services (Part 2)

Research question three was concerned with understanding whether rural voluntary groups offered something that other mental health services did not. This study found that: unlike other mental health services, relationships with staff at the voluntary groups were stable and predictable, which encouraged members to emotionally invest in the relationship. This familiarity restored hope for members. Moreover staff at the voluntary groups placed emphasis on giving time to members. This fostered a sense of inclusion and connectedness, and, as a result, encouraged positive risk taking. Finally, the study found that the voluntary groups were flexible to need by providing structure for those who required regular contact, whilst at the same time being available on an ‘as and when’ basis for those with less need.

Theme 4: Relational Continuity

The importance of familiarity and trust between members and staff yielded considerable therapeutic benefits for members. In the wider policy context, the integration of mental health and social services in community mental health teams (CMHTs) has been part of an integrated service delivery strategy by government to minimise service user distress that arises from service discontinuity and fragmentation. However, the findings from this study have shown that this has not always been successful. A possible reason why voluntary organisations achieve relational continuity for members is low staff turnover and that staff took the time to get to know each person individually. This familiarity allowed staff to know when members were relapsing. This has clear implications for lower-level interventions and preventative care. In terms of recovery, such informal monitoring provided psychological reassurance for members that help was available and that they could rely on this support whether they were experiencing acute symptoms or not. Further qualitative work would be useful to understand more about the role that the voluntary groups play after members experience an acute episode of their illness. In other words, does membership allow for a more speedy recovery from relapse due to the

\textsuperscript{32} In terms of the policy landscape, the Scottish Government (2012c) has piloted several peer support specialist schemes (i.e. where those with lived experience of mental ill-health are employed to help and support others who are experiencing something similar). In the most recent strategy (2012-15) the government acknowledges that peer support schemes are an important aid for recovery and have committed to reviewing the evidence with a view to extending the use of the model (but without committing anything further at this time).
welcoming and accepting attitudes of familiar staff (i.e. this response potentially sends a clear message to members that set-backs are normal and part of life).

The caring practices demonstrated by staff at the organisations included facilitating access for members (e.g. transport) and giving practical support. In the context of recovery, such a ‘philosophy of care’ (Repper & Perkins 2003) prioritises access and inclusion as a way for members to maintain valued social roles and activities. In the current context of health and social care cutbacks, such caring practices by rural voluntary organisations are particularly important as support for the most vulnerable has become increasingly rationed (Collier 2013). The findings from this study demonstrate that the caring practices of voluntary organisations are aligned to policy direction in relation to both recovery and preventative care. For rural service users, such caring practices are arguably even more important given issues around access (Chapter 2).

**Theme 5: Time**

A key difference between the voluntary organisations in the study and other mental health services was the resource of time. In the context of recovery, spending time with members and getting to know them personally not only provided reassurance but also sent a clear message to members that they were worth getting to know. It ensured their needs and wishes were central in the therapeutic process. A further dimension to such personalised care was that it encouraged positive risk-taking. In the context of recovery, positive risk taking involves the person taking on challenges that lead to personal growth and development (Slade 2009a, p. 177). The issue of risk in relation to mental health is an emotive one, with a clear political dimension. However, it is arguable that unless service users are allowed to take positive risks it can essentially be an obstacle to their own growth; resilience is developed through trying and failing (Slade 2009a, p. 177).

**Theme 6: Flexibility**

In the final part of the findings in relation to research question three, it was seen that rural voluntary organisations were flexible to the needs of those who use them. For some, the sense of structure was an important benefit that was missing from other mental health services. For others, it was the physical and psychological availability that marked the difference with other services. As previously noted, the immediate availability of environments that allow service users to feel safe is a key aspect in promoting recovery and enhancing quality of life (Swarbrick 2012). In the context of rurality, such findings
take on an even greater significance. The notion that there was somewhere to go through the day, or attend as and when they wished, can be seen as filling an important gap that other mental health services cannot fill. Further qualitative investigations would, therefore, be useful in order to understand whether structure and availability were as important for urban dwellers on their recovery journey given the range of options that they have.

The concept of recovery represents a move away from a biomedical model to a new paradigm centred on power sharing, ‘expert by training’ and ‘expert by experience’, and which gives primacy to lived experience. Recovery is about recovering an emphasis on the relationship people have with their mental health problems as a counterweight to the overall tendency to see people defined as and by their problems (Joint Position Paper 08 2007). The concept, therefore, calls for all those involved in mental health service provision to see beyond the diagnosis to the individual as a whole. It seems that rural service users who took part in the study are already doing that, seeking a safe environment in which to construct and reconstruct a deeper sense of who they are, a place to experience a sense of self beyond the simple diagnostic label. As the findings from this study have shown, voluntary services provide significant potential in terms of self-definition.

Recovery is highly individualistic and attributable to each in different ways. However, these narratives were similar across geographical locality despite the different historical, cultural and social contexts in which their social lives were located and framed. A key criticism previously noted centred on the lack of consensus as to what the process of recovery involves (Roe et al., 2007; Rudnick 2012a) and yet such an understanding is essential to the development of effective treatment, support and rehabilitation (Repper & Perkins 2003, p. 45). The findings from this study have, therefore, shown the key mechanisms by which the process is promoted and facilitated.

More than anything else, recovery represents a move away from notions of mental illness as a predictable deteriorative course (McGrath & Jarrett 2004) to a more expansive philosophy that is linked with hope and healing. The concept of recovery represents a growing recognition of the importance of finding meaning and value in life, wherever that may be, and to the importance of having a sense of control. As the findings have shown, staff at the voluntary organisations focus on what members can do rather than what they cannot, essentially increasing the likelihood that they will utilise available opportunities and, in doing so, develop new opportunities. It is incumbent on policy
makers and all those involved in service design, therefore, that they listen to those who experience mental health problems, in a way that allows them to help lead the therapeutic relationship. (As one participant in this study noted, the approach of other mental health services has often been about ‘dictating’ and ‘patronising’ service users (Male, Western Highland)). In doing so, it will give more control back to those who, for so long, it has eluded.

8.5.2 Policy Implications for Recovery

Consideration needs to be given to the fact that attending a voluntary group and gathering with other likeminded people is still within the context of mental illness. A possible solution would be to encourage more educational routes, where members, either together or alone, can participate in educational programs that shift attention from ‘the problem’ to something that is unrelated to it. In Highland, the University of the Highlands and Islands (UHI) has a range of outlying learning centres that are designed to be accessed by those living in remote and rural areas. Further links, therefore, between the voluntary organisations and these learning centres could prove useful in terms of opening up further opportunities for participation whilst at the same time facilitating growth for service users.

The recent Scottish Government (2012c) mental health strategy highlights a clear focus on prevention, anticipation and self-management as central to taking mental health policy forward. This direction in policy requires investment in strategies that help service users to maintain good mental health. However, public sector cuts essentially diminish the potential for service providers to achieve this. As a result, this puts further pressure on voluntary organisations to fill this gap whilst at the same time also trying to deal with the knock-on effect of funding cuts to Local Authority budgets. It would, therefore, be useful for policy planning to consider the dimension of giving more time in relation to formal mental health services, to ensure preventative care is achieved.

Mental health services should reduce harmful risk whilst at the same time developing positive risk-taking (focusing more on the latter) which is led by the service user and which maximises opportunities for growth and personal development, again in line with the self-management theme evident in policy. This process should be about collaboration and power sharing between professional and service user by working together to decide what actions are necessary to reduce harmful risks. If differences between professional
and service user arise, these should be discussed and explained until a consensual middle ground is reached.

8.6 Applying the concept of social capital

In the final chapter of this thesis, research question four considered whether the concept of social capital was useful for understanding the benefits and role of rural mental health voluntary groups. It was shown that using the lens of social capital allowed for a clear understanding of the contribution of rural voluntary groups. In particular, the findings highlight the importance of social capital for connecting service users to each other and to their local communities. As outlined in Chapter Two (see p. 56), Putman’s communitarianism (1993a, 2000) was useful in the context of the present study as it incorporates the role of place as an important factor in social life. Moreover, the emphasis on voluntary associations and their potential in fostering norms of reciprocity is central to Putnam’s thesis. The following section will address the theoretical and policy implications in relation to bonding and bridging social capital.

Theme 1: Bonding Social Capital – Exclusive Networks

It was apparent from participants that the strong bonds and emotional closeness with each other was an important resource for them to draw on. In the context of bonding social capital, the findings, therefore, demonstrate that strong social bonds and the sense of trust between members increased resources such as self-esteem (private good) by providing stability and a sense of security. As a result, such closeness encouraged better mental health outcomes (public good) due to increased motivation for self-care and by encouraging help-seeking behaviour (i.e. prevention and promotion) through normalizing mental illness.

Such empirical findings offer an important contribution to the knowledge base. As Chapter Four demonstrates, the social connectedness of rural communities can create significant problems for service users, essentially perpetuating social exclusion. In such a setting, finding places to connect with likeminded people can be difficult and may involve travelling considerable distances. Fear of gossip can ensure mental health problems remain hidden. The implication is that those who require an intervention may only be presenting to mental health services when the symptoms are more severe. From an economic perspective, therefore, such lower-level interventions and preventative care
(in the form of bonding social capital) are far more cost effective than supporting acute illness and addressing crisis situations.

The voluntary organisations also provided a space within which members could materialise their citizenship. Given the issues of stigma and social exclusion highlighted throughout this thesis, places where members could feel a sense of obligation to one another appears important. Indeed, such informal designations of citizenship retain a dynamic of their own which demands explicit consideration (Painter & Philo 1995, p. 115). The assertion from this study, therefore, is that the ways in which members conceive their role at the voluntary groups in relation to social citizenship needs further examination. In particular, in an area where service users have been denied full citizenship (Sayce 2000), where their rights have been subject to suspension (i.e. through involuntary detention) and where they have generally been viewed as passive recipients of care, such dynamic forms of citizenship are highly relevant. In light of the current ‘Big Society’ discourse, there is an increasing emphasis on what it means to be a citizen. The starting point for this renewal of civic society is with the agency of the individual citizen. The policy question then is how to enhance local citizenship so that more power can be taken back by more people at the local level.

**Theme 2: Bridging Social Capital – Inclusive Networks**

The findings evidenced several examples of bridging social capital in relation to the voluntary groups and the opportunities for inclusion and participation that they brought. For example, the organisations had forged strong links with local Community Mental Health Teams (CMHT) which ensured more collaborative care. Within a rural context, this type of social capital is important for building and strengthening the capacity of communities, given the dispersed nature of the population, and the challenge of accessing services (including transport issues). A further benefit was that being able to draw on the resources of the voluntary group had inspired some members to connect with outside agencies/people and, in some instances, even raise awareness about available mental health support (in the form of the local voluntary organisation). This effort at bridging ensured opportunities for participation, whilst also potentially ameliorating the social exclusion of those who may be in need of mental health support. In an era of continual cutbacks such findings again serve to highlight the pivotal role of rural mental health voluntary organisations in terms of their contribution both to members and the wider local community.
In terms of cross-national differences, the study found that Canadian organisations were far more ardent with regards to bridging social capital. The reasons for this are complex. The cultural differences highlighted in Chapter Four suggest that Canadians may be more community orientated given the importance the government places on social cohesion, national identity and national values (Bannerman 2011). Such values could explain the proactive nature of the voluntary groups. A further explanation is that these groups were part of much bigger organisations that operated across all provinces, and in some cases, the world. Infrastructure was in place that helped them to achieve strong links with other community agencies (e.g., Transitional Employment Placements (TEPs)). Such opportunities are also available in Highland in the form of, for example, Training and Guidance Units (TAG) (http://www.taghighland.org.uk/) where those who would potentially benefit from the service can self-refer. However, given the wealth of benefits that participants reported in relation to the voluntary organisations that they attended, it would be useful to have established links with employers embedded within those organisations. Further work to explore more about how members feel about work placements, what impact it has in terms of achieving full competitive employment, and whether it leads to accessing other opportunities and networks would be useful to expand the knowledge base particularly in terms of transferability.

An important impact of bridging social capital was that it provided opportunities to reduce the social distance between members and the rest of the community (see Chapter 7). The issue of mental health stigma remains a persistent problem for all those involved in mental health policy and planning: the social exclusion of service users is perpetuated by such stigma and discrimination. Focusing on opportunities that bridge the gap is a key way to address power differentials between the two. Moreover, forging links with the mainstream community is important because the voluntary groups could otherwise reinforce the service user identity for members thereby restricting opportunities for participation in the normal range of social activities.

Whilst there are on-going issues with definition and how it can be operationalised, the underlying message here is that social capital is an important concept for building social cohesion. Another way to think about the utility of social capital is to consider its opposite, social atomization. Studies have repeatedly shown the detrimental impact of social isolation. For example, mortality rates for people with few social relationships are many times higher than those with larger social networks (McKenzie & Harpham 2006, p. 13). In the current globalised economy, there is a risk that people are indeed more
isolated than ever before. It becomes clear, therefore, why social capital occupies a central aspect of social policy. In the context of mental health, the importance of strategies that enhance the potential for civic engagement becomes self-evident given the issues of stigma and social exclusion that many service users face. Whilst the evidence base remains limited on social capital in relation to mental health, empirical findings from this study have shown that there are numerous benefits both in terms of positive mental health outcomes and for community cohesion.

8.6.1 Policy Implications for Social Capital

Social capital is a non-material asset that can have material benefits (Schneider 2009). Whilst it cannot be observed directly, it can be measured in terms of trust and social networks between individuals. The findings from this study have shown that social capital is important for connecting service users to each other and to their local communities. In an era of increasing limits on public sector expenditure, coupled with the increasing incidence of mental health problems, such findings raise the profile and status of such organisations, essentially offering an important contribution to the debate about ways to promote community belonging. The role of rural voluntary groups in relation to building local social capital deserves greater recognition in policy and investment by government.

The implication from this study is that greater attention needs to be given to strategies that reduce the social distance between the mental health community and wider society (bridging social capital). As this study has shown, such familiarity can be an effective tool in terms of breaking down stigmatising attitudes to mental illness. However, further consideration needs to be given to looking at ways for the voluntary groups to also act as ‘bridges’ to involvement in group activities outside the mental health sector, in order to facilitate service user involvement in diverse avenues such as drama societies, reading groups and arts and crafts groups. Otherwise, the voluntary groups could inadvertently reinforce segregation between service users and the wider community.

This thesis offers an important contribution to understanding how social capital can improve mental health outcomes when embedded within a dense network of social relations. As previously stated, understanding the relationship between social capital and mental health is still in its infancy, therefore, further empirical work is needed in order to inform the knowledge base, and ultimately policy. The Scottish Government has used the concept of social capital as a way of improving outcomes by generating community
belonging and connectedness for service users (see *Towards a Mentally Flourishing Scotland* Scottish Government 2009a). Whilst this is important, there needs to be greater clarity around how the concept is defined (and essentially measured) and how abstract notions such as belonging and connectedness are noted as being achieved.

### 8.7 Direction of Further Research

A key finding from this study is that mental health stigma was less problematic for Canadian participants, despite considerable evidence to the contrary. Interestingly, a large part of the evidence base in Canada is informed by quantitative methodologies. The implication, therefore, is that further qualitative work is needed in order to understand the reality of rural mental health, including whether stigma is something that impacts to a greater or lesser degree in terms of overall quality of life in rural Canada.

The negative aspects of rural living were particularly discernible from the Highland data. Cultural factors such as the role of religion and the prominent role of alcohol consumption offer possible explanations for why stigma is experienced more acutely in Highland. Further research is needed to explore the impact of religion and alcohol for those with mental health problems living on, for example, the Western Isles.

Migration was spoken about by a number of participants in this study, but the reasons cited for moving were different in both countries. This topic warrants further qualitative research with other groups of participants, in order to identify what underlies this difference. Given the complex ways that participants conceived the rural, such work also needs to also explore the role and influence of place in terms of cognitive dispositions and identity formation.

In relation to rural service providers, the results from this study indicate that, in contrast to Highland, rural services in Canada are designed in a way that accommodates rural factors. In Highland, professionals were noted to be under considerable pressure in terms of being able to respond appropriately to service users which, in some instances, had led to longer waiting lists. Additionally, the training needs of Highland professionals were not being met. These results suggest further qualitative work is needed in Highland to explore and unpack these challenges further in order to assess overall impact, particularly in the current service planning landscape (i.e. with the amalgamation of Health and Social Care) and to consider ways to improve continuing professional development and support programmes. Indeed, further wide scale quantitative work would be useful here in order
to provide additional information on if, or how, widespread such challenges are for service providers throughout the Highlands.

The policy drive to recovery-orientated services, has led to an urgent need for more qualitative work on mental health (Davidson et al., 2008) in order to understand what it looks like from the inside and outside. Future research should, therefore, capture the experiences of recovery for rural service users in order to explore more deeply what, if any, are the other factors that help or hinder the process that could inform the knowledge base. It would be useful here to also explore the experiences of those service users who do not subscribe to the recovery ethos as these voices are largely missing from the literature. Moreover, a key finding from the current research centred on motivation. Further qualitative work would, therefore, be useful in order explore what other factors contributed to service users feeling motivated, besides membership of a voluntary group and if, or how, motivation impacted on other areas of their lives.

It would also be useful to do further exploratory work on the sense of self highlighted in this thesis. In line with Davidson and Strauss (1992) the current study noted the way in which this functional sense of self could be appealed to even in the midst of stress and anxiety. This has important implications for those involved in recovery-orientated practice. Further qualitative work would be beneficial in order to understand more about whether the process is the same across all situations (i.e. community and acute settings) and for all mental disorders. Additionally, it would be helpful to understand more about the role that voluntary groups play after members have experienced an acute episode.

In terms of rural/urban differences, comparative work would be useful in order to understand whether structure and availability provided by membership to a voluntary group was equally important for urban dwellers given the range of options that they have.

Research into social capital and mental health is still in its infancy. This study has shown the considerable contribution it makes in relation to positive mental health outcomes via the voluntary sector. Given the statistics on mental health, coupled with a policy imperative of promotion and prevention, there is a need for further investigation of the links between social capital and mental health. Specifically, in what ways does it improve mental health outcomes for service users who are not part of voluntary groups and what other ways can it be used to achieve social cohesion for service users (outwith membership of voluntary groups). Additionally, Canadian participants in this study noted the range of work options they had in relation to work placements (in Highland,
people can self-refer to TAG units). This issue warrants further research given the importance of work in the current social inclusion policy landscape. Thus, further research could explore how members of voluntary groups feel about work placements, whether they necessarily lead to full competitive employment and whether these lead to other opportunities for accessing networks in rural areas.

The current evidence regarding service users’ access to employment and social networks demonstrated in the literature review, highlights the need for a continued focus on social structures, both in terms of their potential to sustain exclusion (Spandler 2007) and in terms of their impact on mental health. For example, in their analysis of 12 developed countries from around the world, Wilkinson and Pickett (2010) found a strong relationship between income inequality and mental illness, with anxiety disorder representing the highest subgroup of mental illness. Additionally, a correlation between low educational attainment and suicide is well evidenced (Petronis et al., 1990; Nock & Kessler 2006; Björkenstam et al., 2011). Such findings demonstrate the powerfully deterministic nature of social inequality. In terms of structural dimensions in rural areas, services such as healthcare and higher education are centralised, meaning rural dwellers have to travel to access them. To compound this, rural transport remains limited and costly (Storey & Brannen 2000). By implication, for those who cannot afford private transport, it can limit access and opportunities; distance in itself can, therefore, create inequality. In terms of mental health, psychiatric services are predominantly urban focused, with in-patient facilities generally located in cities and rural services centralised as far as possible (Nicholson 2008). However, even when services are available, stigma and discrimination can inhibit people from accessing the help they need. Future research, therefore, needs to examine more closely the relationship between social and economic inequality and its effect on mental health in a rural context.

8.8 Strengths and Limitations of this research

A clear theme reiterated throughout this thesis is that the voices of rural service users have remained largely absent from the knowledge base. This study has, therefore, provided the opportunity to hear first-hand accounts of service users talking about their experiences of rural areas. Qualitative studies like this one provide a more in-depth understanding of rural mental health than can be provided by statistics. In particular, it shows the complex ways in which the rural is conceived and experienced by those who use mental health services, as both a source of inclusion and exclusion. The findings
from this study help to show the feelings, the beliefs, the hopes and the fears of rural service users in ways that have often been overlooked. This study may, therefore, sow the seeds for larger qualitative studies that explore these themes further.

Additionally, Chapter Two of this study noted the lack of knowledge on the voluntary sector. This study has, therefore, provided an important contribution to the knowledge base by exploring the role of several rural voluntary groups in both Highland and Canada. Tied in with this role is the process of recovery. Again, an important contribution made by this research is that it offers a critical engagement of recovery as a process, demonstrating the key mechanisms by which it is promoted and facilitated. As previously highlighted, this rigorous analysis around what the process entails has been lacking (Rudnick 2012a). There also remains a significant absence of information around the role of voluntary organisations in relation to recovery in the general literature, making the findings from this study original and valuable.

Finally, the role and benefits of voluntary organisations were also explored in the context of social capital. This was particularly valuable given that the knowledge base remains limited on the relationship between social capital and mental health. The findings from this study have shown the way in which social capital connects service users to each other and to their local communities. Given the interest with social capital in mental health policy, these findings are valuable.

**Limitations**

There are a number of limitations to the current research that are important to acknowledge. By reflecting on these, it allows for a realistic appraisal of the findings and of the nature of carrying out empirical research within the field of mental health. For example, as part of the research design, the manager of each voluntary organisation was asked to identify those individuals they felt would like to take part in the process. Whilst this ensured confidentiality, it also had implications in terms of subjective judgement. In other words, the managers could potentially have selected individuals they thought would be very positive about the role of the voluntary group (Barbour 2008). Nevertheless, by allowing the managers to select participants, it ensured that the researcher played no part in this process, thereby remaining as objective as possible.

This project might have benefitted from a larger number of service user participants. In particular, it would have been of interest to explore whether the issues of concern and the themes identified were also applicable to others. However, whilst the numbers were
relatively small (there were three focus groups carried out in Highland and three in Canada), responses around the rural dynamic, the way in which rural communities were constituted and the implications of this in terms of mental health, were similar for participants in both countries thereby adding weight to the validity of the findings. Commonalities were also discernible in relation to participant experiences of the voluntary groups to which they belonged. Moreover, the aim of qualitative methodologies is not about statistical generalisability but understanding behaviour, values and beliefs in terms of the context in which the research is conducted (Bryman 2004). The benefit is that qualitative methods provide ‘legitimate and valuable’ (Myers 2000) ways to understand how the meanings people ascribe are situated within an historical and social context. Given the complexity of mental health, incorporating context is crucial for reflecting a nuanced understanding of the different ways participants interpret the social world. This was especially important for the present study given its epistemological and ontological orientation.

The lack of ethnic diversity of participants in this study can also be seen as a limitation. Participants were recruited with the intention of capturing the lived experience of mental health problems. Whilst this holistic approach allows for context to be included, it leads to questions around how representative this is given that the experience of mental ill-health may differ for those, for example, from different ethnic backgrounds that live in rural areas. Highly salient for the Canadian sample was the limited number of First Nations people that took part in the study (n=1). However, there were political barriers to wider recruitment in Canada.

One of the limitations to using focus groups, when compared to interviews, is in relation to ensuring all participants have the opportunity to speak. It took a great deal of time to make participants feel comfortable with their own views and opinions, and to reassure them that they all had something worthwhile to contribute. Nevertheless, once the discussion developed, participants were able to build upon each other’s ideas of what it meant to experience a mental health problem in a rural area and what that might mean for them. Thus through the focus group discussions, participants debated and constructed a rich and multi-layered description that led to a shared understanding of the rural dimensions of mental health.
8.9 Final Thoughts on Rural Mental Health

According to the World Health Organisation (WHO) by 2030 mental health problems such as depression will be the leading cause of disease burden globally (WHO 2011). This study has looked at mental health within two countries where efforts have been made to address its social and economic impact, but where issues remain, particularly in remote and rural areas. Research to date has focused largely on urban areas leaving questions remaining as to how accurately current policy thinking reflects the perspective of rural dwellers.

This study adds to the current state of knowledge by focusing on mental health in remote and rural areas. It identified that rural areas are complex and, for inhabitants, infused with meaning in many and varied ways. Capturing the ‘voice’ of mental health service users and providers offered an opening into these micro worlds. The conceptual framework, design and methods of the work enabled the assumptions and preferences of rural social life to be unpacked and explored within a theoretical framework.

The current study incorporated the concepts of recovery and social capital in the context of rurality. Whilst they are in many ways separate concepts, consideration has to be given to the way in which they can be brought together. A key thread that ties them, therefore, is the focus on the individual and the opportunities that are available to them. For example, in order to build and generate social capital, the service user needs to have opportunities available to connect with others and to sustain multi-stranded networks. In this way, using stocks of social capital essentially creates more. In terms of recovery, again the opportunities need to be available for the service user to regain personal responsibility and to engage in a gratifying and meaningful life. The context of rurality, however, adds a further dimension here. In particular, opportunities can be constrained by practical dimensions i.e. areas with limited resources, and also cultural dimensions i.e. local negative attitudes to difference. However, the opportunity to be part of a rural voluntary mental health group evidences numerous benefits in terms of both recovery and social capital. Of interest to policymakers and local service planners is that such opportunities demonstrate clear social and economic benefits, and therefore widen the focus to local rural communities more generally in terms of building local capacity. In bringing these concepts together, therefore, those involved in planning and delivering rural mental health services need to pay increasing attention to how service users can achieve connections and a sense of belonging by ensuring the opportunities are there for them to do so.
Whilst participant descriptions in this study offered a unique and important contribution to current knowledge, these findings point to the need for more, potentially larger scale, qualitative work on mental health in rural areas. The on-going utilisation of the concept of social inclusion within UK mental health policy, coupled with a discernible disjuncture in terms of the lived reality for rural service users found in this study, should serve as a cautionary reminder that the voices of service users need to be heard. More generally, if mental health policies are to be effective, they need to be informed by on-going qualitative research. Such policies need to acknowledge and reflect the unique needs of rural service users (i.e. by paying closer attention to the rural dynamic of social proximity and ultimately stigma). By doing so, it will mean those policies are nuanced to rural need, ensuring the right help and support is available to those who, to date, have largely been ignored.
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APPENDICES
APPENDIX 1

Schedule for service-users:

How did you first hear about this support group?

Did you find it easy to get to in terms of transport and distance?

Did you need additional help to access the support group?

Were you happy with the location?

Were you comfortable attending the group initially or was there anything that made you uncomfortable?

How did you feel after your first visit?

In what way does the support group help you?

Is there any kind of help you get from this support service that you otherwise feel you would not have?

If this service was not available, what impact would this have on your life?

Were you aware/are you now aware of who provides the service [NHS, voluntary sector etc]?

Do you feel better informed about the issues around mental health by attending the group?

Do you think this support service is well known in the community in terms of potential service users?

How important is it that services such as these are provided within your community?

Do you ever meet up with the others outwith the group sessions?

Since you first accessed this service, have you started accessing any other services?

How did you find out about those services?

Did using this service make you feel comfortable accessing others?

In what way do you feel this service or any other could be improved?
APPENDIX 2

Schedule for professionals:

Can you state what your job is and how long you have been doing it?

What does your job involve?

What types of areas in the Highlands do you, or have you, covered?

As part of your job, do you have to deal with other agencies?

If so, what has been your experience of this?

Have you ever experienced any problems working with other services?

Do you think agencies involved in mental health service provision work well together?

As part of your job, are there regular training opportunities?

Are you encouraged to go for further training?

Do you think there is enough training available or could there be more?

Are service-users adequately involved in their care plans?

Do you think service provision is tailored to the (different) rural situations that you have worked within, e.g. does it take into account issues of distance and small populations?

What are the main ‘rural’ problems that you have seen in relation to service provision?

It has been suggested that in rural areas, people are more reluctant to use mental health services because they don’t want people to see them doing so – have you had any experience of how this issue is overcome in service provision?

Do you feel service-provision could be improved and, if so, in what way?

Increasingly, there seems to be a focus on the role of non public sector organizations in service delivery, can you offer some thoughts on this?