Mental Health: Exploring the Current Landscape

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centred
at the heart of care

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Acknowledgements

I would like to extend a heartfelt thank you to all the organisations, professionals, and most importantly, to those with lived experience who took the time to talk with me and share personal experiences. Those conversations were so helpful in aiding my understanding of the sheer complexity of the issue in the current landscape. Whilst my report is focused on what the issues are and what still needs to be done, the determination and care of those who provide or receive mental health support, and those who stand up and advocate, is inspiring and gives me great hope that we can continue to create change and move forward, together.

Executive Foreword

Centred, formally Birchwood Highland, has been at the forefront of supporting people with significant and enduring mental ill-health since 1987. During this time we have seen many changes in the public perception, treatment and understanding of mental ill-health. Of particular interest has been the incidence, treatment, perception and effects of mental ill-health within rural areas, of which there has been very little study. Importantly, this has often led to the perception of the issues that relate to mental ill-health in rural areas to be taken from the standpoint of those in urban areas.

During 2022 we carried out a review of our brand, services and strategies. As one of the few mental health charities to be located in the Highlands of Scotland, one of our core strategies was to develop greater understanding and awareness of rural mental health using a programme of innovative research developed and led by Dr Clare Daly (whose research expertise is rural mental health).

This report digs deep into numerous areas including misconceptions of rural mental health and the complexities that go hand in hand with any study within rural areas. This lack of adequate study and understanding has all too often led to rural areas being misunderstood within policy and viewed as an extension of perceptions and experiences within urban areas; which in turn has had negative effects in terms of the roll out of policy and access to services.

We hope that this report will be the first in a series of studies that examines rural mental health and goes someway to changing the landscape in terms of support and understanding for those that experience mental health problems.

Finally, I would like to thank all those that took part in the study through interviews and meetings. Your support is greatly appreciated.

David Brookfield,
Group Chief Executive, Centred.

Summary

Discussions about mental health have become increasingly mainstream in recent years, with contributions from all sectors and levels of society. Changes in legislation aligned to human rights coupled with state aspirations to achieve parity of esteem between physical and mental health suggest that the subject is being treated with a renewed focus. However, such optimism may be a little premature; the evidence suggests that many service users still experience widespread stigma and exclusion as key features of daily life, further compounded by significant and increasing levels of wealth and income inequality, along with the impact of COVID-19. Additionally, there remains limited understanding of the experience of service users in rural areas despite repeated acknowledgement by some academics. Finally, despite the important role of third sector organisations in terms of providing support to service users, many such organisations are struggling financially due to the impact of COVID-19.

This report seeks to understand the current state of play with regards to the mental health landscape, in order to identify the questions that still need to be asked and what areas need further exploration.

The key areas covered by this report are:

- **Current Context on Mental Health**
- **Rural Mental Health**
- **COVID-19**
- **Structural Inequalities**
- **Third Sector**

1.

Introduction

1. Introduction

It has been many decades since the policy of deinstitutionalisation was introduced in the UK. At the time of its inception (from the 1970s) providing care in the community rather than the asylum was lauded as an important advancement in the provision of mental health care linked to arguments centred on, for example, independent living, enhancing social networks, and improving quality of life, all made possible by therapeutic developments at that time (especially in terms of psychopharmacology); in this way, the narrative was structured around the theme of human rights. Such changes were indeed crucial for helping those experiencing mental distress to feel that they were still part of the community rather than hidden away or banished from sight. However, rather surprisingly, the knowledge base at that time (i.e. following deinstitutionalisation) was limited; few studies sought to examine community mental health care in order to evaluate if, or how well, the policy was working for those it was intended for. In the intervening years there have been significant positive changes with regards to the mental health landscape, most notably the emergence of the recovery paradigm and also the increasing drive to achieve parity of esteem between physical and mental health at state level. The mobilisation of the service user movement has also offered greater opportunities for these historically marginalised voices to be heard. Yet, to date, major issues remain with regards to experiencing mental health problems in the UK. Both anecdotally and in terms of existing evidence it can be seen that many service users (and providers) feel little has changed despite legislative change and major efforts in the form of public campaigns. The most obvious point here relates to the ongoing issue of stigma and discrimination experienced daily by service users; specifically, its insidious nature has been shown to continually impact all the major dimensions of life that are important for human wellbeing and flourishing. In these areas, many service users continue to feel the overbearing weight of the structural system and its many barriers that hinder the innate drive to feel connected. The ongoing retrenchment of state and the cutback to much needed resources has had a compounding effect in this regard and has disproportionately affected the most vulnerable. This trend has continued in the

UK for decades but the consequences are perhaps now being felt in ways previously unseen – the most obvious area here is the issue of crisis support for those experiencing acute mental distress (many are now having to travel significant distances to access support) due to the ever-reducing number of inpatient beds.

Furthermore, the knowledge base on community mental health continues to be conceptualised through an urban-centric lens meaning knowledge on rural service users and providers, and the issues and challenges they face, is limited. Over the years, this research lacuna has been pointed to repeatedly by academics. As the evidence shows, rural areas are complex; even comparisons between rural communities are difficult given the significant differences in, for instance, localised cultural norms and history, and the implications of that for those who are regarded as 'different'. Whilst it is useful to consider wider changes in mental health (i.e. in urban areas) in relation to rural areas, the latter requires far more exploratory work to ensure that the policy landscape adequately reflects their uniqueness in relation to the mental health landscape.

A further point here relates to the staggering levels of inequality now prevalent throughout the UK. Historically, in Scotland there have been major issues with inequalities in terms of poverty and exclusion that have continued to drive poor mental health outcomes (one is advised to read more on the 'Scottish Effect' or the excess mortality in Scotland that cannot be accounted for when compared to other areas of similarity in terms of poverty and deprivation). Indeed, globally the evidence base is robust regarding the relationship between the two; epidemiological studies have repeatedly shown that the very poor are at highest risk for many pathological conditions, including mental disorder. Poverty is regarded as one of the most significant social determinants of health and mental health, and can lead to a range of adverse mental health outcomes, including depressive disorders and suicide. The experience of poverty can also have lasting effects given how it can shape the life trajectory via compromised educational

attainment and ultimately employment. Much has been promoted in policy about creating the right opportunities for service users and whilst this is commendable, the reality suggests many still struggle to secure meaningful employment, essentially creating a double discrimination through poverty and mental health status. In this regard, and in terms of finding real and viable solutions, the wider neoliberal framework has to be considered given that its introduction has aggressively accelerated inequalities within the structural system.

The emergence of a global pandemic potentially has major psychological implications with regards to both existing service users and whole population wellbeing. Emerging evidence shows that, to date, the pandemic has widened inequalities in mental health across gender and age groups, and exacerbated pre-existing inequalities: essentially affecting certain groups more than others (i.e. youth, women, people with existing mental health problems, and those from Black, Asian and Minority Ethnic (BAME) communities). Furthermore, the increasing demand for care as a result of the pandemic has put pressure on the charitable sector, compounded by the ongoing financial impact. Whilst the outlook is uncertain in terms of long-term predictions, the trend is concerning in terms of third sector recovery and renewal work and what this might mean for existing service users/providers and potential new ones.

To this end the following areas are focused on; Current Context on Mental Health: Rural Mental Health: COVID-19: Structural Inequalities: Third Sector.

The following report aims to address these areas within the UK mental health landscape as a way to highlight gaps in knowledge or areas that need further and more detailed exploration. Whilst the interest is primarily with rural mental health, the wider landscape is captured in order to contextualise the subject matter relative to its urban counterpart. To this end the following areas are focused on; Current Context on Mental Health: Rural Mental Health: COVID-19: Structural Inequalities: Third Sector. Each section is concluded with summary points and recommendations, each of which will be expanded on in the conclusion.

2.

Current Context on Mental Health

2. Current Context on Mental Health

2.1 Introduction

The first section explores the current context on mental health in the UK. The section considers the evidence on stigma and discrimination given its ongoing negative impact for those experiencing mental health problems. The expressed aspirations of policy rhetoric in terms of provision versus the reality of constant cutbacks to resources is also addressed.

2.2 Evidence on the Current Context

Mental health problems are one of the main causes of the overall disease burden globally (Vos *et al.*, 2013) with depression the leading cause of disability (World Health Organisation, 2022a). Estimates also suggest that as many as 700,000 die each year from suicide (World Health Organisation, 2021). In the UK, mental health problems affect approximately one in six, with an estimated cost to the economy of £70-100 billion annually (UK Research and Innovation, 2022) and have been identified with contributing to and resulting from social determinants such as socio-economic deprivation and social isolation (Department of Health 2014). In Scotland, around one in four people are affected by mental health problems, with those who are classed as socially excluded to be at a higher risk (Scottish Government, 2020a). Moreover, there has been a continuous rise in the number of prescriptions for antidepressant medication, from 3.8 million in 2007/2008 to 6.6 million in 2017/2018 – an increase of 73% (Clews, 2018).

As many as 700,000 die each year from suicide (World Health Organisation, 2021)

1 in 6 are affected by mental health problems in the UK (UK Research and Innovation, 2022).

1 in 4 are affected by mental health problems in Scotland (Scottish Government, 2020a).

The impact of having a diagnosed, or undiagnosed, mental health problem cannot be underestimated. For an individual, it can create fear, sadness and despair as the familiar and known becomes unfamiliar and strange. It can also leave the

person feeling vulnerable, with a prevailing sense that they are no longer in control of their life. However, the impact and consequence of having a mental health problem is far wider and more sustained in terms of wellbeing and quality of life. For instance, the onset of mental ill-health can significantly disrupt social connections, employment opportunities and, in the long term, can promote suicidal ideation. It can also exclude the person from civic participation and socially valued activities, potentially compounding other inequalities. Indeed, people with mental health problems are among the least likely of any group to find work, be in a steady and long-term relationship, live in decent housing or be socially included in mainstream society (Mental Health Foundation, 2021a). There are also legal implications of being labelled mentally ill. For instance, the rate of custody loss for mothers with a serious mental illness (SMI) is still high (Seeman, 2012). Yet, despite the impact of separating mothers from their children, in some areas there has only been limited training available for mental health nurses involved in Parenting Assessments within some in-patient psychiatric facilities in the UK (Rutherford, 2015).

In recent years, the discussion about mental health has become increasingly mainstream with numerous well known public figures sharing their own experiences of mental illness. Public campaigns by charities such as MIND and SAMH (Scottish Association for Mental Health) have also sought to inform and raise awareness about mental health, and provide resources and support for those who need it. The tragic suicides of high-profile celebrities such as Robin Williams (actor), Avici (DJ and music producer), Caroline Flack (television presenter), Chester Bennington (musician), and Anthony Bourdain (chef and television personality) have further bolstered the discussion on mental health, encouraging a more honest and open dialogue, with the message ‘it’s okay not to be okay’. By shining the spotlight in this way there has also been an attempt to foster compassionate responses and increase awareness about the mental turmoil and distress that people may be hiding (e.g. campaigns such as ‘Be Kind’). Attempts have also been made to challenge traditional gender norms, such as stoicism

amongst men, encouraging them to seek help and to talk about their mental and emotional health. The impact of trauma and the various ways it manifests has also seen more prominence in terms of its role in relation to addiction (see Gabor Maté's 'The Wisdom of Trauma'), early life experiences (see Adverse Childhood Experiences (ACE) framework), and in terms of war and conflict (e.g. Op COURAGE), again raising awareness about the long-term impact of mental health problems and how it can affect the life trajectory.

This shifting landscape is encouraging and suggests that mental health is firmly 'on the map' and in the public consciousness. It also suggests the needs of service users are recognised and that there are increasing opportunities for participation in social and economic life**.** Yet, evidence shows that people with mental health problems are among the most excluded groups in the UK (Boardman, 2011), with nine out of ten experiencing stigma or discrimination (Mental Health Foundation, 2021a). Research by Time to Change (2008) found that stigma, or fear of stigma, continues to create barriers and stop service users from doing things, with a significantly higher proportion shown for women, people living with severe mental illness, those who identify as LGBT+, those with additional disabilities and middle-aged service users. The research also found that 45% of respondents who had a mental health problem in the past five years had chosen not to disclose to an employer; the biggest barriers were fear of being discriminated against (44%) or feeling ashamed (40%).

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: 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.

In Scotland, evidence shows that 56% of people with a mental health condition have experienced stigma and discrimination ('See Me', 2015a). Research has also shown that 48% of workers would be unlikely to tell their employers about mental health problems for fear of losing their job, and 55% think that disclosing a mental illness could result in being passed over for promotion ('See Me', 2015b). Stigma is also an issue within Scottish BAME and asylum seeker/refugee populations, which is further compounded by racism, pre-migration trauma and loss of support networks (Quinn *et al.*, 2011).

In Scotland, evidence shows that 56% of people with a mental health condition have experienced stigma and discrimination.

It is important to address stigma and discrimination because its legacy has created a 'struggle for dignity' for service users (Lilja and Helzen, 2008) and is the major reason for social exclusion (Royal College of Psychiatrists, 2009). Continued stigmatising attitudes to mental ill-health have also been described as having worse consequences that the conditions themselves (Thornicroft *et al.*, 2016). In the UK, campaigns such as Time to Change (England and Wales) and 'See Me' (Scotland) have sought to develop interventions that educate and inform the general public in order to change the way people think and act about mental ill-health. Raising awareness in this way is arguably key for transforming perceptions of mental health generally, and for how service users are perceived and accordingly treated. Yet, in a recent global narrative review by Thornicroft and colleagues (2016) exploring effective interventions to reduce stigma and discrimination, it was found that few published studies globally have focused on the service user's perspective on stigma and discrimination. This seems to be a conspicuous omission given the weight of evidence on its exclusionary potential.

A further point here relates to self-stigma. Specifically, internalising negative messages about mental health can mean that those who experience mental health

problems can end up holding 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 stigmatised can lead to secrecy, withdrawal and isolation that 'decreases the chances of adaptive responding in society' (Hinshaw, 2007: 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 and Perkins, 2008: 17). In line with this, research exploring the experiences of service users in the Highlands of Scotland found that some participants were too embarrassed to access services and were reluctant to let others see them doing so, despite the potential benefits of service support (Daly, 2014). Other participants spoke of a prolonged period of 'coming to terms' with a mental health diagnosis, whilst for others, historical attitudes to mental illness served as a cautionary influence in terms of disclosure. (The impact of stigma in relation to help-seeking in rural areas will be discussed in section 3).

2.2.1 Rhetoric-Reality Gap

An important development in recent decades has been the policy drive to empower service users (most notably driven by the recovery paradigm) to ensure there is service user involvement in shaping policy and the direction of service planning. One can see that with the Scottish Government's explicit aim of putting 'the voice of lived experience at the heart of our approach' (Scottish Government, 2020b). The UK government has also demonstrated this commitment. Whilst this is commendable and vital, again the evidence cannot be ignored. For instance, research by Beresford (2013) found that service users have reported numerous barriers to involvement such as those based on gender, ethnicity, culture, belief, sexuality, age, disability and class; and in relation to where they live, specifically homeless; living in residential services, in prison and travellers/gypsies. The research also found a number of key external barriers that prevented, or made it

difficult, for service users to get or stay involved, thereby serving to potentially magnify existing problems of exclusion:

2.2.2 Key Barriers Included:

• Devaluing service users – not valuing or listening to what they say

• Tokenism – asking for their involvement but not taking it seriously, making it an unproductive experience

• Stigma – the stigma associated with their service user identity discouraging them from associating themselves with it and getting involved on that basis

• Confidence and self-esteem – low levels leaving people to feel that they don't have much to contribute or are worried about whether they will be able to do it. Their disempowerment is sometimes misread as apathy

• Language and culture – the frequent reliance on jargon and other excluding arrangements for involvement, puts off many service users who are not confident in or used to such situations

• Inadequate information about involvement – this is made worse by the frequent lack of appropriate and accessible information about getting involved, discouraging many from taking the first steps to getting involved.

Service Users Barriers to Involvement:
• Devaluing service users
• Tokenism
• Stigma
• Confidence and self-esteem
• Language and culture
• Inadequate information

Such evidence highlights an important 'rhetoric-reality gap' in the mental health landscape, as Unwin (cited in Beresford, 2013) notes:

> 'Involving service users has become a repeated mantra. For decades official reports, service reviews, plans for new developments have, as if by rote, included the phrase 'services users must be involved.' And more recently, the gloss on this has been 'service users must be at the centre of all we do'. Too easily these phrases have been seen as sufficient. A generalised plea for a new approach which could be best delivered through finding a handful of more or less interested service users, and ensuring that they were consulted, brought into the process and in the name of engagement asked to contribute....[T]he few service users involved in this way have been exhausted. Planners and professionals have had an uneasy feeling that they are only hearing partial and inevitably individual views. And critics have muttered about the reliance on 'usual suspects' and the risk of capture by the system. What has been more worrying, has been the tendency to ascribe a simple homogenous view to service users, as if all service users are the same, share the same histories, and have identical views.'
>
> Unwin (cited in Beresford, 2013)

A further point here with regards to the 'rhetoric-reality' gap relates to the cutback of much needed resources for mental health care in the UK. In Scotland, mental health services are notably over-stretched, under-resourced and have been described as 'in crisis' for failing young people (40% of young people referred to CAMS are not seen within the target time of 18 weeks and some have had to wait more than a year to receive treatment) (Smith, 2020; Bol, 2021). Evidence also shows that many people in Scotland are not confident that they would receive quick access or the right support from their GP for mental health difficulties (Mental Health Foundation, 2021b). The past decade has seen a reduction in inpatient beds and staffing shortages, which has had significant implications for those who are in crisis (Porter *et al.*, 2019). Additionally, waiting times have been

up to nearly two years for psychology services in areas such as Caithness (Ross, 2020). GPs, primary care mental health teams and NHS senior managers also report reductions in funding for community services such as drop-ins and counselling support, despite those with severe and enduring mental illness (SMI) reporting increasing social isolation (Mental Health Foundation, 2016).

Recent empirical work exploring the needs of service users in the Highlands of Scotland found that less than a third were getting the help they needed to live well with mental health difficulties (Lyons, 2021), with many reporting feelings of loneliness and insufficient access to services (geography, resources, lengthy waiting times). Participants also felt that professionals did not listen to them or take them seriously. Importantly, the lack of crisis support for those experiencing suicidal ideation was highlighted. In line with this, earlier work by Porter *et al.* (2019) exploring mental health crisis support in Highland found significant gaps in appropriate service provision during more acute phases of mental distress:

"I was eventually seen by a doctor and he said he needed to speak to a consultant so he went off. I waited ages and then a nurse came back and told me I was being discharged. They gave me back my rope and discharged me in the middle of the night."

"20 years ago there was no support and it's the same now."

"I went to the doctor's to try to be seen when I was suicidal and they refused me an appointment. It took three weeks to get an appointment."

"I have never been asked about suicide by my doctor. It's like they don't want to ask the question because they are scared of the answer. If you say yes, they have to do something about it and they have nothing to offer anyway."

"Eighteen months is not unusual."

"I was supposed to be seen by a psychiatrist two years ago. And I've not heard a thing."

"There was an incident when a young girl came in, and she was completely 'away with it'. Her boyfriend was the devil and was going to kill her baby and all that kind of thing. So we (service users) sat with her... for some time, then they went over to the hospital, sat there for another two hours, nobody appeared, so she just went home."

"We had....five people who used to come here at one point, who took their own lives... all in about two years. And...one...had actually gone to the local hospital ... at least two or three times, asking for help. And because... they didn't know what to do with her and just told her to go home. This was over a weekend – a Saturday morning – and she just walked into the river."

Such evidence reinforces the impact of resource cutbacks that have been evident in health and social care in the UK for decades. Whilst such measures take affect at all levels, for both service users and providers, arguably the most vulnerable bear the brunt.

In England, mental health services have been described as 'in crisis', with large parts of the NHS having no psychiatric inpatient care units (PICU) and increasing numbers of people having to travel significant distances from home to receive treatment. An investigation by the British Medical Association (BMA), exploring long journeys to access treatment found that thousands of service users were being sent more than 30 miles for services such as acute care, psychiatric intensive care, or rehabilitation (Cooper, 2017). According to the investigation there has been a 'startling rise' in service users being sent out of area for treatment (nearly 40% between 2014-15 and 2016-17 to 5,876), with one reportedly sent from Somerset to the Highlands which covered 587 miles 1. In some areas, there have been no beds at all for female patients in need of

[1] The number of NHS mental health beds in England has fallen by 73% from 67,100 in 1987-88 to just 18,400. That was part of a drive to provide more "care in the community" and treat more mentally ill people in or close to their homes. However, the promised expansion of out-of-hospital mental health care has not occurred on anywhere near the scale originally envisaged. https://www.theguardian.com/society/2019/nov/06/hundreds-of-mental-health-beds-needed-to-end-shameful-out-of-area-care

psychiatric care. As a consequence, doctors, nurses and social workers are having to spend hours sourcing alternative arrangements which takes attention away from other severely ill patients. As a result of lengthy waiting times for mental health treatment, it has also been found that two-fifths of patients contact emergency or crisis services, with 11% ending up in A&E. Those with severe mental illness (SMI) were found to be left waiting up to two years for treatment, whilst others were left waiting up to four years for treatment of depression, anxiety and suicidal thoughts. For over a third, this had resulted in a decline in their mental health (Royal College of Psychiatrists, 2020).

2.3 Summary Points

1. **Issue: Stigma remains an ongoing issue**

Recommendation: More qualitative research is needed to understand the impact of stigma, and to explore strategies that are used to negate it. Specific groups include women, people living with severe mental illness, those who identify as LGBT+, those with additional disabilities, middle-aged service users and migrants/refugees.

2. **Issue: Limited crisis support**

Recommendation: The issue of crisis support provision across the UK is concerning. More research is needed here, across multiple sites, to understand the impact from both service user and service provider perspectives. Such research is crucial to inform policy and to identify appropriate and sustainable solutions.

3.

Rural Mental Health

3. Rural Mental Health

3.1 Introduction

The following section looks in more detail at the available evidence on rural mental health and what some of the implications are for help seeking within closely-knit communities.

3.2 Evidence on Rural Mental Health

The evidence suggests that narratives on mental health, and associated discourses, have become increasingly mainstream. This is further enhanced by the policy landscape that is aiming to achieve parity of esteem between physical and mental health, and to ensure the voices of service users are central to that process. However, to date, much of what is known about community-based mental health is conceptualised and approached through an urban centric model; the knowledge base remains limited with regards to the experiences of rural service users and providers (Nicholson, 2008; Skerratt *et al*., 2017). This ongoing gap is an important omission because it leaves knowledge partial and perpetuates notions such as the 'rural idyll' which has implications in the context of mental health. Specifically, idealised conceptions of country living can contribute to stress and stigma, leading to further social isolation for service users and, in some instances, hostility towards them from other community members (Watkins and Jacoby, 2007).

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 (Letvak, 2002). 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 and Brown, 2002). ther challenges include a lack of: resources, high quality research, awareness amongst rural populations of symptoms of depression, adequate support in

providing and organising mental health services through Community Mental Health Teams, and the psychological suffering that can be brought on in rural areas through, for example, farming crises. There is also 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, 2001). For example, once mental health problems occur for the rural dweller, it can become increasingly difficult for them to re-join society and they may become trapped indefinitely on the margins of it. 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 (Nicholson, 2008).

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 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 Wainer and Chester, 2000; Hutner and Windle, 2001; 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

Rural areas fare better than urban ones in terms of mental health even though rural areas have consistently higher suicide rates for men

treatment and practical support, suggesting that available figures on prevalence of mental health problems may not accurately reflect the scale of the problem. Discussing aspects of rural life Nicholson (2008) 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, 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, earlier work by Parr *et al*. (2004) set out to understand these lifeworlds of rural 'mad' people in 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: 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

Rural 'mad' people in the Highlands of Scotland... experienced a 'complex and untidy story of...tolerance and rejection...'.

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: 24).

A more recent study on rural mental health by the Scottish Rural University College (SRUC), found that accessibility remained a significant barrier to using mental health services. Specifically, public transport remained a major barrier in terms of receiving proper care to manage mental health problems. The study also found that local community dynamics were experienced in different ways; for some, local connections were supportive and strong, whilst for others it felt as parochial and judgemental. Importantly, most respondents did not feel able to be open about their mental health problems in their community (Skerratt *et al.*, 2017).

In line with this, research exploring mental health in the Highlands of Scotland and Canada found that living in a rural area with a mental health problem can be a source of inclusion *and* exclusion (Daly, 2014). In particular, 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 wider 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, the study 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 make it difficult to

maintain anonymity and confidentiality which can inhibit help-seeing behaviours. Moreover, the decision to engage with mental health services was found to potentially have lifelong implications due to the 'fixed' service user identity ascribed by other community members. Stigma also remained a major barrier that made it difficult for service users to forge friendships or make new social connections. Specifically, local rural culture was found to shape negative perceptions of mental health, leading to stigmatising attitudes by some local community members. Yet, rural places were conceived as positive places to live as a service user despite limited mental health support; many participants felt a strong affinity with them because they engendered a sense of belonging.

The inherent challenges of using mental health services in rural communities is highly salient to any discussions on rural mental health. In pragmatic terms, 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). However, in terms of social proximity, the relative lack of anonymity in rural areas can 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 rural mental health are not truly representative of the scale of the problem. A final point relates to the sheer complexity of rural environments.

There are substantial differences, for example, between rural villages in Cornwall (populated disproportionately by retired incomers), and those of the Highlands of Scotland where the same families have often lived for generations. 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). 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, for instance, 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 in rural environments.

3.3 Summary Points

1. Issue: Limited knowledge on rural mental health

Recommendation: More research is needed generally on rural mental health but also specifically to understand the processes of inclusion and exclusion (and a more detailed look at gendered dimensions), as a way to inform policies that maximise the former.

4.

COVID-19

4. COVID-19

4.1 Introduction

It would be remiss to write about the current mental health landscape in the UK without dedicating some time to looking at the ongoing effects of COVID-19. The following section explores the current evidence in relation to mental health and wellbeing, both generally and in relation to rural areas. Nevertheless, the evidence should be reflected on with caution given that we are still in the midst of the pandemic and by implication, the full extent of its impact has not yet been fully captured or understood.

4.2 Current Evidence on COVID-19

The outbreak of the global pandemic has arguably disrupted all areas of social, political, and economic life for people around the world. Since its emergence it has exacted a high death toll, and left many physically debilitated as they recover from it, or in a desperate financial situation due to loss of employment and/or the closure of business. However, its effects have been disproportionately felt by those living in poverty, which has pushed them further down the poverty trap. For instance, in terms of food poverty, some food banks have reported an average increase in demand of 59%, 17 times higher than in the previous year (Hetherington, 2020). In terms of debt, 3.8 million low-income households across the UK are now in arrears, and 4.4 million have had to take on new or increased borrowing through the pandemic (Earwaker and Bestwick, 2021). In terms of employment, those on zero-hours or temporary contracts ('the precariat') have been found to be four times more likely to lose their job, and those in poor-quality jobs (in terms of hours and pay) are disproportionately at risk of losing their job or having much needed hours reduced compared to other workers in the same sector and with the same job haracteristics (Sandor, 2021). The consequent

The outbreak of the global pandemic has arguably disrupted all areas of social, political, and economic life for people around the world.

rise in job losses has also created intense competition for lower-paid occupations (McDonald and Wenham, 2021).

4.3 Mental Health

Aside from social and economic dimensions, the impact of COVID-19 on mental health is concerning and, indeed, the forewarning that the pandemic will be closely followed by 'a mental health crisis of similar magnitude' (Wilkins and Anderson, 2021: 4) underlies the point that mental health, both in terms of its promotion and prevention, is something that affects all of us.

The pandemic will be closely followed by 'a mental health crisis of similar magnitude'.

According to the World Health Organisation (WHO) poor mental health is associated with rapid social change, social exclusion, unhealthy lifestyle, physical ill-health and human rights violations (WHO, 20022b). To this end, one can assume that the pandemic has negatively impacted on mental health in various ways. Whilst the features of lockdown have varied between the nation-states in the UK, and regionally within each nation, the defining aspect has been the control of movement in order to contain the spread of the virus. Orders to 'stay at home', to wear masks in public spaces and to socially distance have been the common refrain by governments as a way to manage things. Given the unprecedented nature of state responses to the pandemic, it is clear that most, if not all, have been affected by lockdown measures to some degree. In Scotland, emerging evidence highlights an overall deterioration in the population's mental health and wellbeing since the start of the pandemic, and the expectation of a worsening incidence of mental health disorders, of traumatic reactions, substance misuse, self-harm and suicide (Scottish Government, 2020b). Additionally, economic and employment impacts are likely to have a significant effect on mental health, and are likely to be unevenly distributed suggesting a compounding effect of existing inequalities. In line with this, quantitative research by Banks and Xu (2020) has shown that COVID-19 has widened inequalities in mental health across gender and age groups, and has

exacerbated pre-existing inequalities. Specifically, their research has found that in the first two months of lockdown mental health worsened by 8.1%, with young people and women experiencing the largest declines in mental health. Those with existing poor mental health before the pandemic suffered the largest deterioration in mental health, with those reporting severe problems more than doubling. Other evidence has found that almost half of the UK population reported high levels of anxiety in March (beginning of the lockdown) compared to the previous year (Office for National Statistics, 2020a).

A study of service user experiences by Scottish mental health charity SAMH (2020) found that 45 per cent felt the quality of their treatment had got worse and less frequent since the start of lockdown, with 58 per cent feeling that there were less opportunities to discuss their care or treatment (n-725). The survey found that people who were coping very or quite badly before the pandemic had significantly increased (from 23% to 45%). Those experiencing suicidal ideation rose by 3% and yet 10% did not seek treatment despite feeling they needed it. Importantly, almost half of participants received no information on how their treatment would be affected by the pandemic. Furthermore, some also reported confusion around the priority of services and orders to protect the NHS.

Research by mental health charity Mind (2020), exploring the experiences and challenges of COVID-19 for people with pre-existing mental health problems in England and Wales, found that more than two thirds reported worsening mental health during lockdown (n-16,000). Pre-existing inequalities had also worsened for women; people with disabilities; those living in social housing; people with eating disorders, obsessive compulsive disorder, or personality disorder; and frontline workers. The pandemic was also found to disproportionately affect people from Black, Asian and Minority Ethnic (BAME) communities. Key drivers for poor mental health included restrictions on seeing people and worries about the health of family and friends. Boredom and

loneliness were also found to be a major issue for young people. Importantly 1 in 3 adults and 1 in 4 young people chose not to access support during lockdown because they did not think they deserved it, whilst for those that did, 1 in 4 experienced barriers due to not feeling comfortable with technology.

1 in 3 adults and 1 in 4 young people chose not to access support during lockdown because they did not think they deserved it.

Within the global news media, much has been speculated and written about with regards to the impact of COVID-19 on suicide. Headlines such as, '150,000 Brits will die an 'avoidable death' during coronavirus pandemic through depression, domestic violence and suicides' (Chalmers, 2020) has further fuelled the belief that the pandemic has led to an increase in suicide rates. However, evidence shows that suicide rates did not increase during the early stages of the pandemic and were lower in 2020 compared to the previous year in Scotland (BBC, 2021) and between April and July 2020 in England and Wales [2] (Office for National Statistics, 2020b). This finding is also consistent on a global scale. Research by Pirkis *et al.*, (2021) using data from 21 countries (16 high-income and 5 upper-middle income countries), based on national or state level suicide data, found no evidence of an increase in suicide rates from the start of the pandemic until the end of July 2020. (However, it is important to note that the study only focused on the early stages of the pandemic and does not predict future outcomes). Whilst there are risk factors and stressors such as anxiety about infection, social isolation, disrupted care, and economic uncertainty, the evidence acts as a reminder to engage critically with media reporting, given the latter's ability not only

[2] However, the figures captured are within a certain timeframe in the context of covid – more generally the issue of suicide remains a public health issue and the figures remain stubbornly high, particularly in the Highlands of Scotland – https://www.researchgate.net/publication/307992539_Suicide_in_the_Highlands_of_Scotland where figures captured in 2019 were the highest since records began, almost doubling the 2014 total https://www.pressandjournal.co.uk/fp/news/highlands-islands/2676211/number-of-suicides-in-highland-in-2019-was-the-highest-since-records-began/).

to reflect and reinforce cultural conventions and sense-making, but to shape public perceptions and attitudes (Sowden *et al.*, 2021).

For young people, COVID-19 has been particularly difficult and has meant disruption to friendships and important social activities, as well as the cancellation of exams and all the uncertainty that entails. Sadly, the lack of physical contact caused by the lockdown has led to what has been described as 'skin hunger' for some young people or a yearning for physical contact (e.g. hugs) (Wilkins and Anderson, 2021). In the last 25 years, rates of depression and anxiety in young people have increased by 70% (yet many do not receive any clinical support) (Stroud and Brien, 2018). However, since the outbreak of the pandemic, mental health conditions have risen faster due to the fear of the virus, the strain of living in lockdown and fear for the future; many young people with existing mental health conditions have experienced a worsening of symptoms, partly due to the restructuring of service support (Wilkins and Anderson, 2021). In line with this, research by the Mental Health Foundation (2022) found that the proportion of young people reporting suicidal thoughts or feelings (22%) was more than double that of the population as a whole (10%). The research also found that four in ten 18-24-year-olds experienced loneliness during the pandemic – more than any other age group surveyed. Whilst uncertainty about the impact of the pandemic on education and future prospects is noted, the research highlights that a significant number of children and young people are dealing with a range of complex and traumatic experiences during lockdown but without the regular coping strategies and escape mechanisms offered via school and social activities (see also The Children's Society report 'Life on hold: children's well-being and Covid-19', and Barnardo's report 'Generation Lockdown').

In the last 25 years, rates of depression and anxiety in young people have increased by 70%.

4.4 Covid and Rurality

The above evidence shows that COVID-19 has exacerbated existing inequalities which has significant implications for rural areas given the longstanding themes of

infrastructure, accessibility, and the recruitment and retention of health professionals (Daly, 2014). In their work exploring the impact of COVID-19 for some rural marginalised communities (LGBT+; young carers; refugees and asylum seekers) Thompson and Lejac (2021) found that the pandemic had affected the mental health of 93% of participants. The research found that many respondents felt isolated and cut off from the local community. Whilst some were able to stay connected digitally, many felt excluded in terms of connectivity due to poor infrastructure and high cost. Limited public transport had also compounded social isolation. Stigma and discrimination were repeated themes, with respondents feeling that more needed to be done to raise awareness of mental health more broadly. Some also reported feeling isolated or discriminated against due to their mental health and felt that discussions on the topic needed to be more normalised. Others raised concerns about the financial impact of the pandemic on the rural economy and expressed concern over a 'bleak' future. For refugees and asylum-seekers, covid had created numerous barriers in terms of education and language acquisition, as well as much needed local 'face to face' support which had impacted on the integration process and, consequently, their overall mental health and wellbeing. Strategies to support good mental health included utilising 'hyper-local' connections, specifically interpersonal networks of family and friends.

The pandemic had affected the mental health of 93% of participants.

Research commissioned by the Samaritans (2022) also found that nearly half (45 per cent) of men aged between 20 and 59 in rural communities in the UK have experienced feelings of anxiety during lockdown, with over a third experiencing difficulty with sleep. Importantly, over a third felt that important relationships had been put under strain. In terms of help-seeking, 32% felt that talking to others helped with worries and concerns.

As part of their 'Landscapes of Support' project exploring mental health and farming in the UK, the University of Reading (2022) found that 67% of participants

reported feeling more stressed during the pandemic than before, 63% felt more anxious, 38% felt more depressed, and 12% felt more suicidal. The evidence suggests that the primary reasons for worsening mental health amongst farmers ranged from having less social contact as a result of lockdowns and social distancing, and social events moving online (which was particularly challenging for families with poor internet connections). According to those who provide support, the key reasons pushing farmers to make contact during the pandemic was loneliness, family or relationship issues, financial problems, illness and pressure of regulations and government inspections. Barriers to support included fear of stigma associated with help-seeking, lack of knowledge about available support, travelling distance to access help, and time constraints. Combined together the researchers rather ominously have concluded that, 'the pandemic is storing up problems that will manifest themselves more seriously later' [3].

Scottish Government's strategic response to the mental health impacts of COVID-19:

The strategy focuses on the following:

- Whole Population Mental Health
- Employment
- Ensuring Equity and Equality
- Socio-Economic Inequalities
- Relationships
- Children, Young People and Families
- Women and Girls' Mental Health
- People With Long-Term Physical Health Conditions and Disabilities
- Older People
- People Who Have Suffered Bereavement and Loss
- Distress Interventions
- Suicide Prevention

[3] Available 24-hour support has now been set up for farming families – see 'We Are Farming Minds'.

- Clinical Rehabilitation and Recovery from Covid-19 Infection
- A Long-Term, Trauma-Informed Approach to Recovery
- Digital Innovations
- Mental Health Services
- Forensic Mental Health Services
- Mental Health Law

Each area has associated actions that the government intends to operationalise as a way to enhance or improve existing mental health provision. (The reader is encouraged to access the strategy and explore it in more detail). It is important to acknowledge the official aspirations of government as a way to assess if, or how well, progress is being made. As shown previously, the gap between well-polished rhetoric and the reality of the mental health landscape is a persistent theme, particularly with regards to the impact of stigma for service users and also the ongoing cutback to resources. Indeed, the impact of the pandemic on the future viability of third sector organisations (see Section 6) leaves questions as to how well this aspiration can be realised by the government (see '16.16 - Strategic and Partnership Work with the Third Sector'). Furthermore, the strategy places increasing emphasis on digital technologies (e.g. cCBT) which may not be the most effective for meeting some needs given the additional information that can be gathered by professionals via face to face consultations, and also that many service users may not feel confident using technology as part of therapeutic intervention.

Finally, the strategy identifies supporting the wellbeing of the health and social care workforce as part of its renewal work. A budget of £8 million has been allocated for wellbeing support in 21/22 and services such as staff wellbeing 'hubs' and 'suites', helplines and listening services, as well as Occupational Health and Spiritual Care are in place to enhance resilience and signpost to relevant mental health services. However, allocation of funds may result in little more than tokenism rather than meaningful and sustainable solutions for health and social

care workers, particularly given the existing challenges in mental health provision, essentially raising the question as to how well this can be achieved and how effective it can be. To this end, the contribution of academic research is even more vital. Specifically, given the predictions with regards to mental health across the population, and the paucity of rural mental health research, there is a need for qualitative research that explores the experiences and challenges of providing mental health support in an unprecedented and highly stressful wider context, within rural environments.

4.5 Summary Points

1. Issue: COVID-19 has widened inequalities in mental health across gender and age groups, and exacerbated pre-existing inequalities.

Recommendation: More qualitative research is needed to understand the impact of COVID-19 on young people, women, and existing service users – in order to inform long-term interventions that are effective and context-specific.

2. Issue: COVID-19 has been challenging for rural marginalised communities

Recommendation: To continue to build on the current evidence base with more in-depth work within each of these communities. Additionally, research exploring mental health and wellbeing specific digital technologies as part of a viable solution to lockdowns, social distancing and remote engagement is recommended.

5.

Structural Inequalities and the Cumulative Effects of Disadvantage

5. Structural Inequalities and the Cumulative Effects of Disadvantage

5.1 Introduction

As previously noted, mental health service users continue to experience exclusion in all the major dimensions of life, with poverty a consistent reality for many. The following section, therefore, considers the relationship between poverty and mental ill-health with a particular focus on the impact and influence of the wider neo-liberal framework.

5.2 Evidence on Structural Inequalities

Mental illness is complex and multicausal; ranging from a vague sense of psychological distress, to specific medical diagnoses and behavioural disorders (Lorenz *et al.*, 2004: 75). As previously noted, 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: 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. For refugees, poor housing conditions and living in deprived areas has been found to lead to even greater marginalisation which has impacted negatively on mental health (Quinn *et al.*, 2011). Furthermore, epidemiological studies have repeatedly shown that the very poor are at highest risk for many pathological conditions, including mental disorder (Albee and 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.

The very poor are at highest risk for many pathological conditions, including mental disorder.

Whilst the genesis of mental ill-health is complex, the increasing levels of depression and anxiety suggest that it is a reaction to, and a consequence of, the demands of modern life, particularly in relation to economic constraint. Evidence from the third sector shows that some charities are supporting increasing numbers of people per month who are experiencing financial problems coupled with either anxiety or depression (Bachelor, 2013; Thornhill, 2019; StepChange, 2022). Additionally, a survey by Citizens Advice UK (2015) found that 40% of participants reported that constant worrying about having enough money to buy food and other essentials after rent, mortgage and bills was a feature of daily life. In an earlier survey it was also found that over half reported that debt has affected their relationships with partners and children, and nearly 3 in 4 said debt worries were having an impact on their mental health, while 1 in 2 said their physical health was affected. Of those who were experiencing health problems, just over half had experienced a panic or anxiety attack, and 79% reported losing sleep most nights because of debt (Citizens Advice UK, 2012). Recent NHS data has found that one in three 'sick notes' handed out by GP's are for mental health problems, with a 14% rise in 'sick notes' related to stress and anxiety (NHS Digital, 2017), figures referred to as 'alarming' by the Royal College of Psychiatrists (Donnelly, 2017). Additionally, research exploring stress found that not having enough money to meet basic needs was one of the top three listed sources of stress. The research also found that 74% of adults felt so stressed they were overwhelmed or unable to cope in the past year; 32% of adults had suicidal feelings due to stress and 16% had self-harmed as a result of stress (Mental Health Foundation, 2018).

74% of adults felt so stressed they were overwhelmed or unable to cope in the past year; 32% of adults had suicidal feelings due to stress and 16% had self-harmed as a result

The experience of living in poverty, particularly long-term, can have far reaching consequences in areas such as education, employment, health, and the overall quality of how life is experienced, i.e. mental health and wellbeing, which has a

cumulative impact for individuals, families, and communities (Elliott, 2016). Poverty is regarded as one of the most significant social determinants of health and mental health, intersecting with all other determinants (including gender, race/ethnicity, and community). The experience of poverty can lead to a range of adverse mental health outcomes, including depressive disorders, anxiety disorders, psychological distress, and suicide. For children, growing up in poverty is associated with lower educational achievement, poor cognitive and behaviour outcomes, increased delinquency, depressive and anxiety disorders; and higher rates of almost every psychiatric disorder in adulthood. In this way, its impact on mental health can prevent individuals and families from finding a way out of poverty thereby creating a vicious, intergenerational cycle (Simon *et al.*, 2018).

Figures on poverty are often used as part of the evidence base for policy interventions. However, whilst important, statistics do not give a nuanced understanding of the reality of what it is like to live in poverty on a day-to-day basis and how this affects psychological wellbeing. The fear of not having enough money to pay the rent, or enough food to last each month is real and a constant presence in the lives of many. Some people simply cannot afford to heat their homes for extended periods and can obtain only the minimum of poor-quality food. Some cannot even afford to wash their children's school uniform. In a recent media report about schools in England, it was found that some primary schools have opted to wash the pupils uniforms and are routinely topping up inadequate lunch boxes; pupils from impoverished homes are arriving at school 'in flimsy canvas shoes year round, often hungry and ill-prepared for a day of learning' (Bennett, 2018). Furthermore, some schools have found that not only were some children too poor to afford 10p for a slice of toast at the Breakfast Club but that some parents were collapsing on the premises due to malnutrition. Local GPs are even finding evidence for rickets, a disease prevalent during the Victorian era (McVeigh, 2014).

Not only were some children too poor to afford 10p for a slice of toast at the Breakfast Club but that some parents were collapsing on the premises due to malnutrition.

A further consequence of the pressures of contemporary society is that more are trying to cope by turning to drugs and alcohol. In a recent series by the BBC (Drugland) looking at drug use in Bristol it was found that the problem is so widespread it has required a very different approach (education and support as opposed to arrest) by authorities and support services as they struggle to deal with the overwhelming numbers of those who are addicted. Scotland also has a serious problem with drugs and alcohol consumption; specifically, Scotland has the highest per-capita drug-related death rate in Europe with 1,264 deaths recorded in 2019 (27% higher than the previous year and the highest since records began in 1996) (Stäuber, 2021).

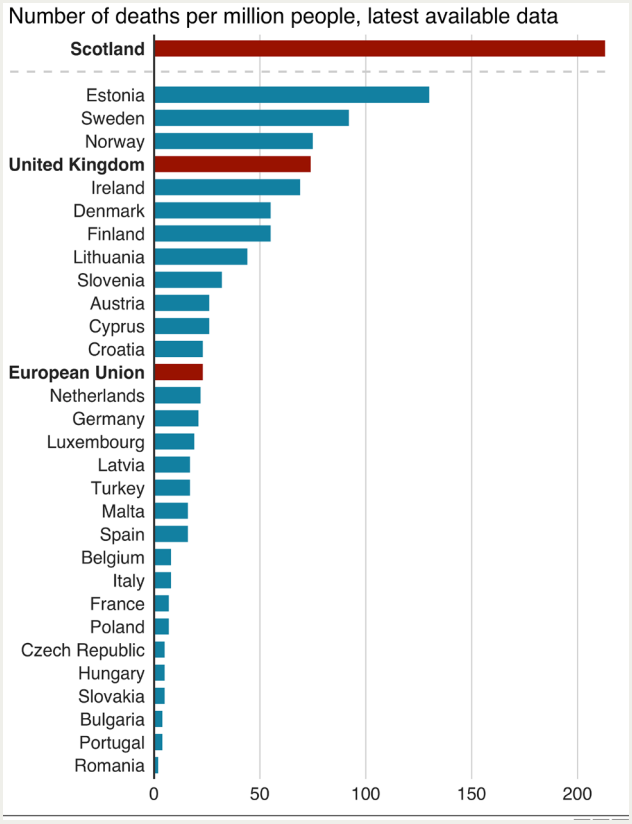

Figure 1: Drug-related deaths per million people (Source: BBC, 2019)

In terms of alcohol, a recent monitoring report showed that in 2015 an average of 22 people per week died due to an alcohol-related cause – 54% higher than in England and Wales. In the most deprived areas, alcohol-related deaths were six times higher than in the least deprived areas, while alcohol-related hospital stays were nine times higher (Public Health Scotland, 2017). In rural areas such as the Scottish Highlands, excessive levels of alcohol consumption have become so widely accepted it has become a cultural norm (Anderson and Plant, 1996; Dean, 2002; Daly, 2014).

A further point here relates to the impact of socioeconomic inequality on the mental and physical health of pregnant women. In a recent landmark study

involving more than 1 million births in NHS hospitals in England (between April 2015 and March 2017), researchers have found that socioeconomic inequalities account for 24% of all stillbirths, 19% of preterm births, and 31% of cases of foetal growth restriction (FGR) and would not have occurred if all women had the same risk of adverse pregnancy outcomes as women in the least deprived group. Moreover, pregnancy complications disproportionately affected Black and minority-ethnic women: 12% of all stillbirths, 1% of preterm births and 17% of FGR cases have been attributed to ethnic inequality. The evidence shows that 53.3% of stillbirths and 71.7% of FGR cases were found among South Asian women living in the most deprived fifth of neighbourhoods in England, whilst 53.7% of stillbirths and 55% of FGR cases were found among Black women from the most deprived neighbourhoods. Such evidence highlights the interrelated and compounding nature of poverty, racism and discrimination, and the tragic impact it can have on the mental and physical health of poor women as they experience pregnancy (Gregory, 2021).

12% of all stillbirths, 1% of preterm births and 17% of FGR cases have been attributed to ethnic inequality.

5.2.1 Rural Poverty and Mental Health

For rural areas, the impact of poverty on mental health is not well evidenced partly because rural poverty is less visible. Despite prevailing notions of the 'rural idyll', it can be seen that rural environments are complex and diverse. Although many rural areas in the UK are affluent, this is not always the case and even within more wealthy rural communities there is significant deprivation and inequality**.** However, attempts to officially capture and quantify this, such as through material disadvantage, are limited and not sufficiently nuanced to pinpoint the pockets of deprivation that exist among, for instance, rural affluence meaning that an area can be classified as 'not deprived' when in fact there is serious endemic poverty and deprivation within it (Local Government Association, 2017). Area-level measures of deprivation also fail to capture rural households experiencing disadvantage because rural deprivation can be more dispersed leading to

inadequate resources and interventions being located in those areas (Thomson, 2016). Yet, disproportionate numbers of people in rural areas are on no wages or low wages. Additionally, many local rural economies rely heavily on tourism making them particularly vulnerable to the impact of, for instance, Brexit. Whilst employment and self-employment is generally higher in rural areas, part-time and seasonal work are also more common, and average earnings are less (Nicholson, 2008). The cost of living is higher in rural areas and the requirement to travel large distances places a heavier burden in terms of fuel (i.e. fuel poverty). Rural areas are also often poorly served by mental health services, specifically psychiatric in-patient facilities are located in more urban areas and services serving rural communities are centralised as far as is possible. A further element is the constant retrenchment of statutory services (driven my austerity measures), that have disproportionately affected rural dwellers given the limited availability of existing service provision. Combined, these factors have created a challenging environment for rural dwellers who find themselves in poverty, particularly in relation to mental health and wellbeing.

Despite this, and the fact that a sizeable minority of the UK live in rural places (around 30% in England and Wales, and 20% in Scotland) there remains a dearth of studies exploring the experience of poverty for rural mental health service users. Yet internationally, depression among rural women is recognised as a major public health concern (Simmons *et al.,* 2008). In Scotland, the proportion of households experiencing low-income poverty living in rural areas is approximately 13% (Thomson, 2016). Approximately 30,000 people living in rural areas live in the 20% most deprived parts of Scotland. However, it is estimated that 150,000 people (1 in 8 individuals) living in rural Scotland are living in income poverty. Given that the poor are more likely to be exposed to stressful life events (such as unemployment, crime and illness) which can potentially lower self-esteem and a sense of control (Amato and Zuo, 1992), and combined with rural aspects such as infrastructure and accessibility

It is estimated that 150,000 people (1 in 8 individuals) living in rural Scotland are living in income poverty.

discussed previously, it is arguable that the experience of poverty and how it impacts mental health and wellbeing differs in terms of rural versus urban environments. However, more qualitative work is needed here in the context of mental health. Specifically, there is a lack of knowledge on the impact of poverty and its influence on daily life for service users, how it shapes perceptions of rural community life and the ability to connect with others, and the degree of influence it has on accessing available services, within the context of rural mental health. Such evidence is key for informing policies that are appropriate and relevant within a rural context.

5.2.2 Inequality: Health and Social Outcomes

Over recent decades, evidence has shown that disadvantaged social circumstances are associated with increased health risks (Department of Health and Human Services (DHHS), 1980; Kempson, 1996; Wilkinson, 1997; Acheson, 1998; Kunst *et al.*, 2005; Marmot and Wilkinson, 2009), making health inequalities a key feature of contemporary international policy development (Currie *et al.*, 2012). In the UK, publication of the landmark book *The Spirit Level* has facilitated an increasing interest in the relationship between inequality and health and social problems. Collating data from countries around the world, the authors demonstrate that more unequal societies evidence poor outcomes across a range of indicators, including life expectancy, teenage pregnancy, and math proficiency and literacy (Wilkinson and Pickett, 2009). In terms of mental illness, the data indicates significant differences between countries in relation to how equal they are: in countries such as Japan, Germany, Spain and Italy 5%-10% of the adult population have suffered from any mental illness in the past year, but in the USA more than 25% have (see below graph).

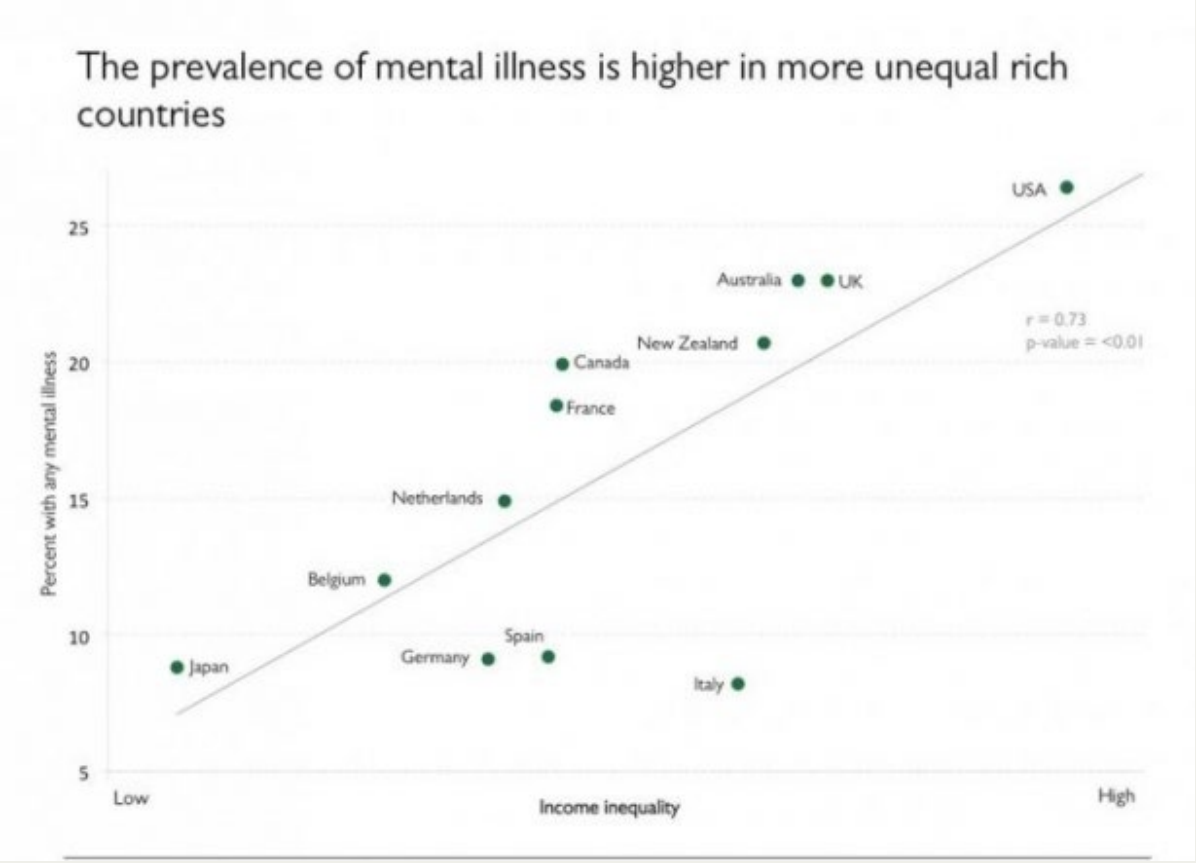

Figure 2: Prevalence of mental illness in different countries (source: Wilkinson and Pickett, 2009)

In line with this, a review of the evidence by Rowlingson (2011) found a correlation between income inequality and a range of health and social problems. Moreover, major studies in the UK on the social determinants of health have found a clear link between socio-economic background and health. For example, the Marmot Review found that in England, those living on the poorest neighbourhoods will, on average, die seven years earlier than people living in the richest neighbourhoods (The Marmot Review, 2010).

The explanation put forward by Wilkinson and Picket (2009) links to psycho-social factors such as 'status anxiety'. From this perspective, income inequality creates hierarchical relations ranging from high status to low status that increase competition and cause stress, essentially leading to poor health and social outcomes. So important are these dimensions of social life that, according to the authors, lack of friends and low status are among the most important sources of chronic stress affecting the health of populations in rich countries (p. 201). In this

context, social judgements and evaluations matter given the connotations that each status carries. In relation to living in deprived areas Wilkinson notes:

> 'what your housing says about you - your sense of how your housing reflects your status, the fact that you live on an estate that other people look down upon, that limits your chances to feel you're a functioning member of society'
>
> (Wilkinson, cited in Devichand, 2010)

In line with this, the wider evidence suggests that the psychosocial effects of social position accounts for a larger part of health inequalities (Wilkinson, 1997).

In Scotland, an Audit Scotland report (2012) found that there were 'significant and long-standing health inequalities' (p. 2) in the country, with deprivation being the key determinant. In particular, the report found that those living in more affluent areas tend to live longer and have significantly better health. The incidence of lung disease, binge drinking (amongst men) and obesity (amongst women) were all found to be higher in deprived areas. Such findings are supported by other research which highlights that people living in the most deprived areas (of Glasgow) have life expectancy 12 years shorter than those living in more affluent areas (NHS Greater Glasgow and Clyde, 2007). Living in deprived areas of Scotland also has worse health outcomes for children (Scottish Government, 2010) and for ethnic minorities (Netto *et al*., 2011). Moreover, people living in deprived areas are twice as likely to consult a GP for anxiety and are three times more likely to commit suicide (Audit Scotland 2012; Public Health Scotland, 2021), demonstrating the detrimental physical and mental health outcomes that emerge as a result of such inequality. In England, levels of psychotic disorders are 9 times higher in people in the lowest fifth (quintile) of household income compared to the highest, whilst psychosis is up to 15 times higher among people compared to the general population (Public Health England, 2018).

Psychosis is up to 15 times higher among people who are homeless compared to the general population.

The relationship between social and economic inequality, and its impact on mental and physical health is complex but the evidence clearly shows that the unequal distribution of the social determinants of health (such as education, housing and employment) matter because it drives inequality which in turn impacts negatively on mental health (see Figure 3).

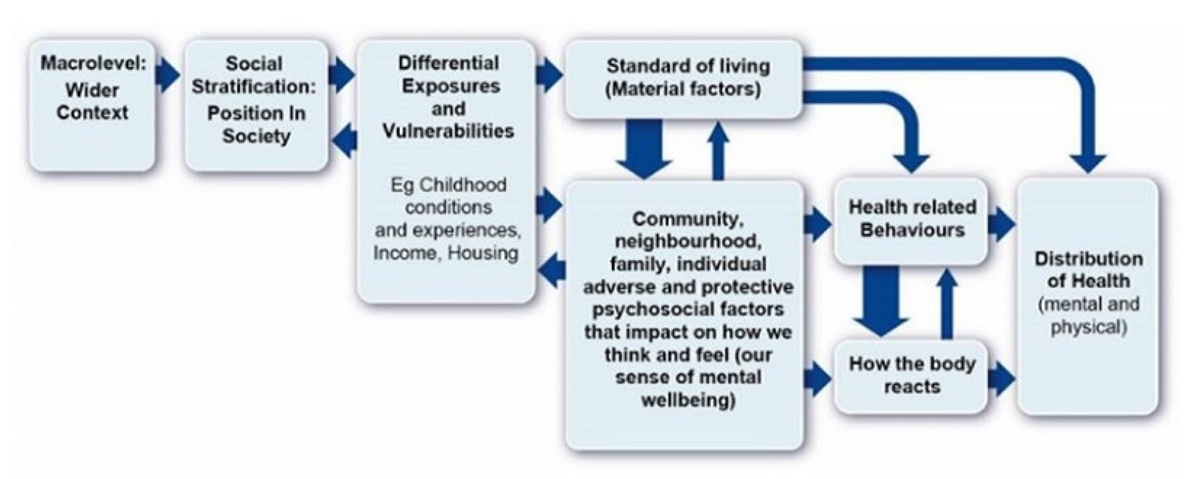

Figure 3: Psychosocial pathways (source Public Health England, 2018)

The above sections show what the impact of inequality is for the mental health and wellbeing of the population. It is useful, therefore, to dedicate some time to understanding the neo-liberal framework within which many inequalities have accelerated.

5.2.3 Neo-Liberalism

The doctrine of neoliberalism is essentially about the primacy of market freedom and a limited state. Its theoretical premise is that the operations of the free market should order social and economic life so that individuals can pursue their own interests, that individual rights are safeguarded, and that economic dynamism, efficiency and prosperity will be guaranteed (Mooney, 2004). In essence, the imperative of the neo-liberal project is to reify the concept of meritocracy and individual gain over the struggles for collective rights and responsibilities:

Neoliberalism is essentially about capital accumulation and economic growth, it therefore promotes the message that the individual is responsible for their own wellbeing, regardless of the conditions they live in.

> 'Neoliberalism is in the first instance a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade. The role of the state is to create and preserve an institutional framework appropriate to such practices. The state has to guarantee, for example, the quality and integrity of money. It must also set up those military, defence, police, and legal structures and functions required to secure private property rights and to guarantee, by force if need be, the proper functioning of markets. Furthermore, if markets do not exist (in areas such as land, water, education, health care, social security, or environmental pollution) then they must be created, by state action if necessary. But beyond these tasks the state should not venture. State interventions in markets (once created) must be kept to a bare minimum because, according to the theory, the state cannot possibly possess enough information to second-guess market signals (prices) and because powerful interest groups will inevitably distort and bias state interventions (particularly in democracies) for their own benefit.'
>
> (Harvey, 2005: 2)

Hay (2004, cited in Mooney, 2004) ascribes seven core elements to neo-liberalism:

- A confidence in the market as an efficient mechanism for the allocation of scarce resources.
- A belief in the desirability of a global regime of free trade and free capital mobility.
- A belief in the desirability of a limited and non-interventionist role for the state in the market.
- A rejection of governments seeking to manage economies through investment in and ownership of companies and sectors.
- A commitment to the removal of those welfare benefits which might be seen to act as disincentives to labour market participation.
- A defence of labour-market flexibility and the promotion of cost competitiveness.

- A confidence in the efficiency of market mechanisms in the provision of public goods.

5.2.4 Neoliberalism and the Welfare State

The doctrine of neoliberalism is essentially about capital accumulation and economic growth, it therefore promotes the message that the individual is responsible for their own wellbeing, regardless of the conditions they live in (Romstein, 2012). In this way, society's political and economic institutions should be liberal and capitalist but supplemented by a constitutionally limited democracy and a modest welfare state (Vallier, 2021). The drive for a 'laissez-faire' or 'minimalist' state (and an increasingly anti-welfarist agenda), have been evident in the UK since Margaret Thatcher's government in the late 1970s. Successive governments since that time have adopted policy measures that continue to align to neoliberal thinking, in particular the reduction in public expenditure, and the reforms to welfare, housing and education provision under austerity measures. According to proponents, neoliberalism has allowed for the more efficient operation of the free market which results in a dynamic economy and faster growth, however its shift from a peripheral minority-thinking concept to the central organising economic principle globally has had significant implications for income and wealth distribution which in turn has a) disproportionately affected the most vulnerable and disadvantaged b) impacted on overall happiness and wellbeing at societal level. As Metcalf (2017) notes:

> '....Of course the goal [of neoliberalism] was to weaken the welfare state and... – always – to cut taxes and deregulate. But "neoliberalism" indicates something more.....It was a way of reordering social reality, and of rethinking our status as individuals.....You see how pervasively we are now urged to think of ourselves as proprietors of our own talents and initiative, how glibly we are told to compete and adapt. You see the extent to which a language formerly confined to chalkboard simplifications describing commodity markets (competition, perfect information, rational behaviour) has been applied to all of society, until it has invaded the grit of our personal lives, and how the attitude of the salesman has become enmeshed in all modes of self-expression....In short, "neoliberalism" is not simply a name for pro-market policies, or for the compromises with finance capitalism.....It is a name for a premise that, quietly, has come to regulate all we practise and believe: that competition is the only legitimate organising principle for human activity'
>
> (Metcalf, 2017)

The promotion of individualism (one of the key tropes of neoliberalism), however, is at odds with the struggle for social justice and collective rights. It is unsurprising then that the welfare state is the key area within which these ideas collide, and from which the biggest impacts have been felt. For instance, initiatives designed to help benefit recipients into employment is increasingly about compulsion, coercion and benefit sanctions for non-compliance (Levitas, 2004; Crisis, 2015). In the context of mental health, such welfare conditionality has significant implications. For instance, evidence has shown that welfare conditionality does not have a positive impact on behavioural change and return to employment for people with mental health problems. Additionally, those categorised as unfit for work are excluded from back-to-work support. The evidence also shows that mental health is invalidated within the welfare system (given the neoliberal rationale), and the pressure and poverty arising from conditionality and sanctions potentially exacerbate mental health problems (Stewart *et al.,* 2020). It is also worth considering the historical example of Atos, the private company hired by the

government at that time (New Labour) to administer Work Capability Assessments (WCA). Atos came under heavy criticism for ruling that individuals were fit to work in some cases shortly before they died. Others committed suicide due to the outcomes of the assessment system (Gentleman, 2013). Such assessments were described as 'not for purpose' by the British Medical Association (BMA) because they involved a computer-based system of checklists that had little regard for the complexity of the needs of the disabled and the sick (Meacher, 2013). More recent evidence shows that the introduction of the Universal Credit scheme has led to an increase in psychological distress (but not employment) for those affected by the policy (Mahase, 2020).

Universal Credit scheme has led to an increase in psychological distress (but not employment) for those affected by the policy.

The drive to calculate and standardise, on the premise of the rational actor, that permeates welfare policies has significant implications with regards to service users due to the fact that mental health problems vary in intensity, duration and aetiology. Also, 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 and Hoek, 2008; Lawn *et al.*, 2010). The power differentials produced through neoliberal policies that focus on economic, rather than human rights indicators, can also lead to a category of disempowered people, whose health needs are subordinated to the markets (Sakellariou and Rotarou, 2017). Furthermore, the idea of paid work as the primary route to 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). Furthermore, the centrality of paid work within neoliberal thinking undermines the legitimacy of non-employment; 'work' is essentially restricted to market-based activity. Indeed, 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 and Perkins, 2008: 134) suggests that quantity, not quality, is central to employment indicators.

Within this paradigm a binary mode of 'desirable' versus 'undesirable' is created; 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, such thinking does not recognise the reality of what it means to live with a mental illness; its unpredictable nature can mean that being able to perform work on a regular basis becomes untenable. Importantly, testimonies of those with lived experience provide a more nuanced understanding of what is considered to be of value or productive (by those who experience mental health problems), one that in many ways challenges the claims of neoliberalism. For example, the preoccupation with labour market participation, reflecting neoliberal 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. For some, volunteer work, or simply supporting others through peer-support is felt to be more important, valuable and meaningful (Daly, 2014).

A binary mode of 'desirable' versus 'undesirable' is created.

5.2.5 'The One Percent Problem'

The promotion of competition and individualism that permeates neoliberal thinking projects a rather narrow framework of belonging, one that has significant consequences for those who find themselves outside of it. Whilst its influence can be felt in diverse areas of the social system, its implicit purposes are economic. The essential message is that material wellbeing and individual gain are the number one priority, in this way it promotes a 'normalisation' discourse; those who fall outside of the parameters for whatever reason (e.g. the vulnerable) find themselves in a rather precarious position that can adversely impact all areas of their life. Importantly, they may find themselves subject to regulation in order to

fix their excluded position. By implication it suggests the mainstream is functional, desirable and essentially trouble-free. Yet, 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 and its psychological impact.

In their recent work, social epidemiologists Wilkinson and Pickett (2018) explore the inner impact of inequality and how it impacts mental wellbeing. In particular, the authors show that greater inequality heightens social threat and status anxiety, which in turn evokes feelings of shame which feed into an instinct for withdrawal, submission and subordination: specifically, as status competition and anxiety increase, people become less friendly, less altruistic and more likely to put others down. Such judgments are detrimental on an individual level i.e. it can increase anxieties about self-worth and impact on a person's ability to connect with others and, on a wider scale, by impacting on the functioning of communities, thus damaging whole societies. The evidence presented shows that depression, psychotic symptoms, schizophrenia and narcissistic traits are all significantly more common in more unequal societies (see Figure 4).

> 'Given that people with these disorders are at one end of a continuum of much more widespread but less severe problems, the evidence points to the very serious costs of greater inequality across entire populations, in terms of the personal anguish which so many suffer'
>
> Wilkinson and Pickett (2018, p. 44)

Aside from the psychological consequences of inequality, there are also impacts to social cohesion: in particular, evidence demonstrates decreased levels of civic participation in more unequal societies. In this way, inequality impacts the wellbeing of entire populations.

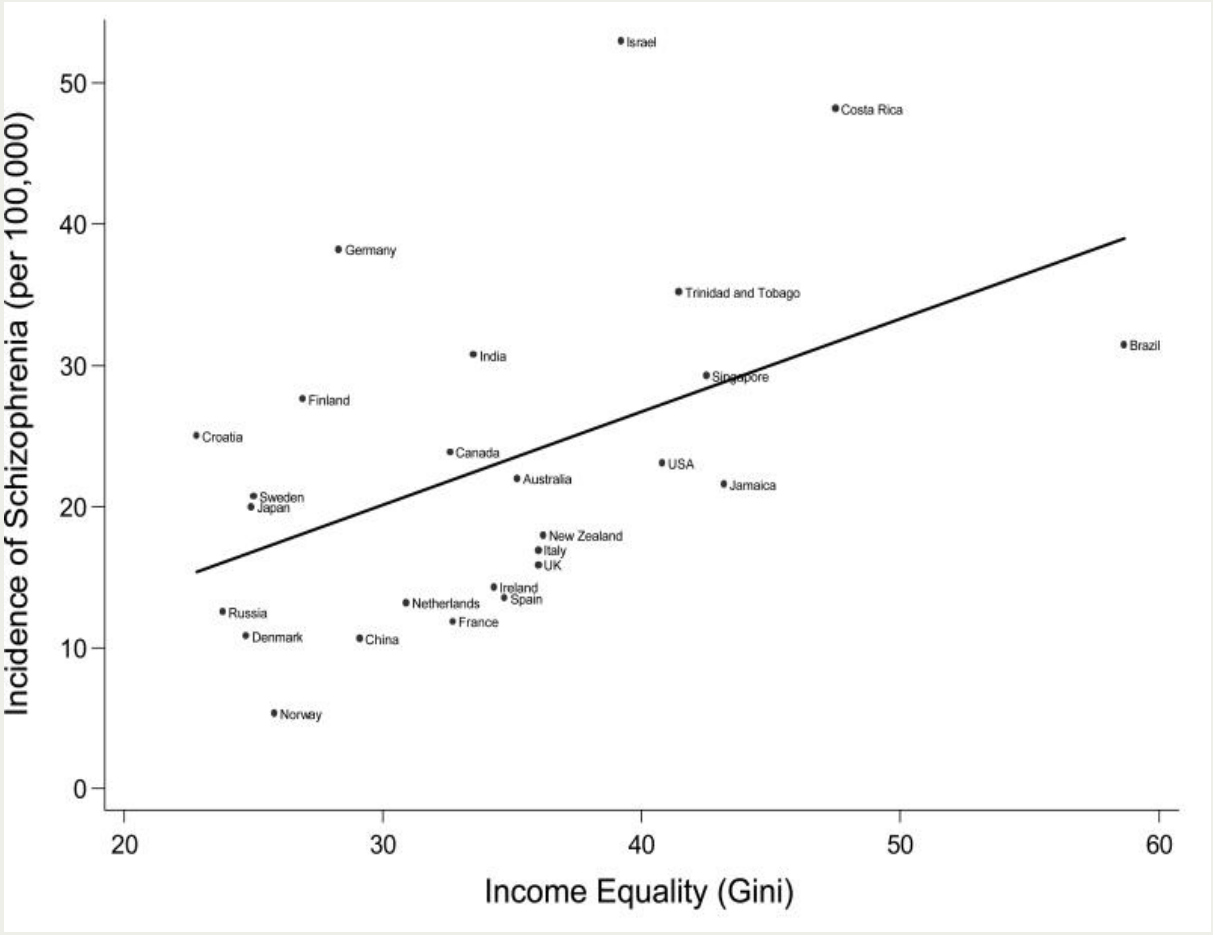

Figure 4: Income **inequality** *and incidence of schizophrenia (source: Burns et al., 2014)*

It is beyond the scope of this report to provide an extensive review on the impact of wealth and income inequality. Yet, it is worth noting the increasing concentration of wealth ownership in the hands of a minority given the implications with regards to mental health and wellbeing. In the UK, for instance, the 1000 richest people own more wealth than the poorest 40% of the population. In capturing this extreme inequality in the US, labour economist Sylvia Allegretto notes that in 2007 the six heirs to the Wal-Mart empire commanded wealth of $6.97 billion, equivalent to the wealth of the entire bottom 30 percent of US society (Worstall, 2011). Currently in the US, the top 0.01% own roughly the same wealth as that owned by the bottom 90% of the population (The Divide, 2015). However, there has also been a significant underestimation of wealth inequality in the UK. In a recent report it was found that almost a quarter of all household wealth is held

by the richest 1% of the population. Specifically, the top 1% have almost £800bn more wealth than suggested by official statistics, meaning that inequality has been far higher than previously thought (Savage, 2021). Commenting on the implementation of the neoliberal project and the extreme levels of inequality that have occurred as a result, previous Economic Adviser to Government, Sir Alan Budd notes,

> 'I wish we'd never got into this state. I wish we'd never had these extraordinarily high rewards. I didn't realise that was going to happen. Maybe others always knew perfectly well that this would be the result of it, but I think that that is unfortunate and I regret it'
>
> (The Divide, 2015)

The impact of neoliberalism has also been felt globally, particularly with regards to welfare programs where an attempt has been made to dismantle social protections in the interests of free market enterprise. As the renowned intellectual Noam Chomsky notes:

> 'Neoliberalism is a general assault on the world's population that takes different forms in different places but it's based on the same kinds of conceptions.....and people have suffered everywhere...every place that the neoliberal principles have been applied, it's been harmful to the general populations...in the US there's been stagnation or decline for about 30 years for a majority of the population ....but if you take a look at the minimum wage.....through the huge growth period of the 1950s and 1960s, it showed productivity that started to break in the late 1970s when the neoliberal assault began. If the minimum wage had continued to grow it would now probably be about $20 an hour, so when people are talking about $15 an hour they're saying 'let's keep it low' and that holds for everything....real male wages are now roughly what they were in the late 1960s....the figures just came out a couple days ago about median household incomes, they're now lower than they were seven or eight years ago and it's been pretty flat ever since [the] neoliberal assault.....it's a technically different form in Europe, a worse form in many ways,... Greece, Spain, England have been targeted by very reactionary economic policies, even worse than here...the idea of austerity during recession, even the IMF thinks it's ridiculous and from an economic point of view yes sure it's an absurdity but that doesn't mean it's foolish, it's a very good instrument of class war....it's undermining the major achievements of Europe since the Second World War... what we call welfare state programs are being

> significantly undermined....in England it's almost startling to see....for example the National Health Service....[is] probably one of the best health systems in the world, they're now trying to make it like the American system which may be the worst system in the world... literally about twice the per capita costs of other countries and some of the worst outcomes, extensive bureaucracy, enormous costs, poor outcomes.... the same is happening in Canada, these are just different manifestations of the neoliberal programs.
>
> (Free Will, 2020)

As previously mentioned, the impact on health and social care budgets, specifically the cutback to much-needed resources, has had significant implications with regards to mental health in-patient beds, waiting times, and crisis support, again disproportionately affecting the vulnerable.

5.3 Summary Points

1. **Issue: Poverty remains one of the most significant social determinants of health and mental health**

Recommendation: given the increasing levels of poverty, research is needed to evaluate the most effective and sustainable solutions that can help individuals and families find their way out of the 'poverty trap'. Interventions should prioritise human wellbeing and thriving as part of their aim; the type of work a person has is just as important to their wellbeing as simply having a job.

2. **Issue: The impact of poverty on mental health is not well evidenced in rural areas**

Recommendation: More qualitative work is needed to understand the impact of poverty and its influence on daily life for service users, how it shapes perceptions of rural community life and the ability to connect with others, and the degree of influence it has on accessing available services. Such evidence is key for informing policies that are appropriate and relevant within a rural context.

3. **Issue: Scotland has a serious problem with drugs and alcohol consumption**

Recommendation: innovative pilots modelled on international case studies may be helpful in this regard; in particular, therapeutic treatments that specifically deal with the role of trauma in addiction should be considered, and trauma-based therapy should be made freely available, particularly in communities with higher rates of addiction. Additionally, more financial support should be provided to those organisations focused on building social capital and helping those recovering from addiction to build their connections within communities.

4. **Issue: living in deprived areas leads to significantly worse mental and physical outcomes, including shorter life expectancy.**

Recommendation: More research is needed to understand the relationship between social and economic inequality, and its impact on mental and physical health. Concepts such as 'status anxiety' are particularly useful in this regard for exploring the experiences of those who live in deprived areas. Given the hidden nature of rural poverty, research in these geographical areas should be prioritised.

5. **Issue: the introduction of neoliberalism has led to significant wealth and income inequality which in turn has disproportionately affected the most vulnerable and disadvantaged, and impacted on overall wellbeing at societal level.**

Recommendation: more research is needed to understand the impact of neoliberalism, i.e. using the theory as part of the research framework, both for existing service users and for the general population.

6. **Issue: neoliberalism has weakened the welfare state and invalidated the experience of mental ill-health.**

Recommendation: further qualitative research that captures the voices of those with lived experience is vital to ensure welfare planning remains true to its original intentions. Additionally, significantly more research is needed to hear from service users about the types of support interventions that could help them access better opportunities in terms of meaningful employment.

6.

Third Sector

6. Third Sector

6.1 Introduction

The final section of this report considers some of the challenges currently facing third sector organisations and their ability to provide health and social care support, specifically in the context of a global pandemic.

6.2 Locating the Third Sector Within the Mental Health Service Landscape

In the UK, the transfer of care from the asylum to the community, as a result of the policy of deinstitutionalisation, has meant there are now a number of primary and secondary agencies involved in providing care to those with 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) whilst secondary services are available in the form of community-based social, housing and voluntary sector services (e.g. community support delivered by charities, Community Day Services, Supported Employment Schemes, Befriending Schemes, Advocacy, Self Help and Peer-Support groups). Within this landscape, the Third Sector has played an increasingly prominent role in terms of delivering health and social care support 4. 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 third 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.

[4] 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, Community and Social Enterprise sector (VCSE). It includes voluntary and community organisations, social enterprises and cooperatives.

6.2.1 Value of the Sector:

The voluntary sector has occupied a prominent position in health and social care delivery in the UK, particularly since the 1980s. From the literature, it can be seen that there is general agreement of the significant and wide-reaching impact of such organisations within the sector. For instance, the voluntary sector (charities are the largest single category within this sector) plays a pivotal role in supporting mental health service users in the community, from providing supported housing, social support, 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 and Kitson, 2007). As Weaks (2015) notes,

> The role of the voluntary and community organisations in supporting mental health conditions is well established. These organisations are rooted in their communities, are trusted by the people they work with, have a long history of social action and user-led interventions, sit outside of clinical settings, and are able to offer significant and effective levels of support.'
>
> (Weaks, 2015)

Research highlights that voluntary sector 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, nd). Evidence shows that they promote empowerment for members, both at an individual level (psychological empowerment) and a community level (community empowerment) (Matthew, 2001); they can alleviate loneliness, and instil motivation in terms of sustained group

Research highlights that voluntary sector 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 .

engagement (Malpas and Weekes, 2001). Furthermore, they can facilitate and promote the recovery process in vital ways (see the work of Centred, see also Daly, 2014) due to their highly individualised and personal approach. Such organisations also have the ability to offer choice and respond flexibly (Bristow *et al*., 2009), provide knowledge and expertise to meet complex personal needs (Woolvin, 2013) and to help service users overcome experiences of marginalisation and exclusion from mainstream society (Milligan, 2000). Indeed, according to the Scottish Government (2017) they make 'life-changing, and life-saving interventions every day'.

According to the Scottish Government (2017) they make 'life-changing, and life-saving interventions every day'.

It is beyond the scope of this report to examine the historical relationship between the voluntary and statutory sector, or the increasing emphasis on partnerships and the 'contract culture' (see Daly, 2014), however, suffice it to say, voluntary sector organisations have been 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), were 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. Furthermore, there is a limited knowledge base on the voluntary sector in rural areas (Scottish Council for Voluntary Organisations, 2003).

6.2.2 Impact of the pandemic on charities in the UK

Aside from these longer-term issues for the sector, early evidence shows

the significant economic impact of the pandemic on charities:

Since the COVID-19 pandemic, research by the Charity Commission (2021) shows that:

- the majority (90%) of charities experienced some form of negative impact as a result of the COVID-19 pandemic, whether on service delivery, finances, or staff morale due to months of frustration and uncertainty - these ill effects will likely reverberate through the sector for some time to come
- the majority (60%) saw a loss of income, and a third (32%) said they experienced a shortage of volunteers
- over half (62%) of those asked anticipated some level of threat to their charity's financial viability in the next 12 months
- restrictions put in place to help stop the spread of the virus meant that charity shops had to close and traditional ways of fundraising had to stop or change

Research by NCVO (2021) has found that

- the impact of the pandemic has been "uneven and unpredictable" on voluntary organisations and warns of projected declines in funding from all income sources in the next financial year
- nearly half (47%) of charities have said their income had dropped and have had to use their cash reserves
- 44% of respondents said they could rely on cash reserves for six months, while 9% said they had no cash reserves or not enough to last a month

The challenges facing charities is also occurring at the same time as Local Authorities struggle to meet increased demands for care services due to the pandemic (and hence will need to partner more with the voluntary sector in response). The following extract captures the reality for charities involved in social care:

> From March 2020, charities in the social care business, faced a huge surge in demand for their services. This was coupled with uncertainty about future income as fundraising events were cancelled, income from charity shops stopped, and additional costs were incurred in the scramble to adapt services to the crisis situation. Charity trustees were faced with competing legal and ethical obligations. Should they continue as long as possible to provide services, adapt those services to pandemic circumstances and meet the charitable purposes for which they were originally established? Or should they be prudent with the resources entrusted to them and scale right back on spending during the pandemic so that they could continue operating in some form for as long as possible?
>
> Much grant funding is short-term and for projects, leaving no resources for infrastructure core costs. So many charities, especially our medium-sized and smaller charities, operate hand-to-mouth – struggling to maintain cash flows and dependent on fundraising events for unrestricted funds.
>
> Looking ahead, our charities - from the large national names to local community associations- are facing intractable financial problems. We can expect to see hasty mergers and take-overs within the charity sector as well as huge staff redundancies as the Government's job-retention provisions are phased out. Some charities, including those delivering much needed front-line care services, will be left as mere shadows of their former selves and others will be wound up (Inside Government, 2022).
>
> (Weaks, 2015)

Given the crucial role charities play within their local communities, this calls for more empirical research that explores their contributions and, in particular, how they are navigating the pandemic landscape.

Our charities - from the large national names to local community associations- are facing intractable financial problems.

6.3 Summary Points

1. **Issue: Covid has put significant pressure on charities in terms of their financial viability**

Recommendation: Needs-assessments are vital to ensure that such organisations do not remain 'at risk' and are supported in their long-term planning to achieve sustainability.

2. **Issue: There is a limited knowledge base on the voluntary sector in rural areas**

Recommendation: More research is needed to explore the impact and contribution that the sector plays in rural areas, particularly with regards to mental health.

7.

Conclusion

7. Conclusion

Moving the loci of mental health care from the asylum to the community in the 1970s was heralded in the UK as a progressive move, reflecting the aim of improving quality of life and enhancing social connection, yet in the intervening years the evidence shows something quite different. Despite sustained attempts to break down stigma and to empower service users through campaigns, or to educate and inform the general public about mental health issues, people with mental health problems are among the most excluded groups in the UK; this disconnection occurs in terms of employment opportunities, friendships, relationships, decent housing – areas that are vital for human wellbeing. Furthermore, the knowledge base remains limited on what it means to experience stigma on a daily basis for those who use mental health services, or to understand more about potential strategies that are deployed to ameliorate some of its more extreme manifestations. Such evidence is arguably crucial to ensure that policy interventions are moving in the right direction and are effective. The onset of the pandemic has perhaps served to demonstrate, or remind people, about the delicate balance in maintaining good mental health and it is here that there is an opportunity to reduce the chasm in binary thinking on mental health (mad versus normal). To this end, the broader approach in terms of mental wellbeing across the whole population is vital.[5] However, the scale of the problem cannot be ignored. For instance, suicide rates (particularly in the Highlands); and drug and alcohol consumption remain a serious public health issue in Scotland. The relentless cutback to resources has also created numerous challenges in terms of providing mental health support and receiving it: budgets can only be stretched so far. A further point relates to the major issue with crisis provision in some areas – the quotes mentioned in this report serve as a reminder that there is still work to be done in terms of getting it right for service users. Such evidence is important

[5] In Scotland, the government has shown an increasing interest in wellbeing. For instance, the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) has been included as part of the Scottish Health Survey (however, it has been criticised for its lack of sensitivity in highlighting the difference in wellbeing among the groups most at risk of poor mental health) and it has now implemented the National Wellbeing Programme.

to flag as a way to measure the gap in policy rhetoric versus the reality of living with a mental health problem, or indeed its potential as a yardstick to measure progress. To this end, more research is needed to fill gaps in knowledge and to ensure the voice of lived experience really is at the heart of the government's approach.

It is important to note that the aim of this report is to identify gaps and the 'what next', it is not to discount the major advancements that have occurred in the mental health landscape. Indeed, there are increasing opportunities for service users to have their voices heard and their experiences included as core components of policy and practice. Such progress has also reinforced the powerful role service providers (along with family, friends and community) play in the lives of those experiencing mental health problems. Yet, there is still some way to go: the fight for parity of esteem between physical and mental health does not have an end date, it is a continuous, dynamic process which ebbs and flows. The key here is that we must remain vigilant and keep mental health and wellbeing at the core of the political framework.

A further point relates to the perpetuation of urban-centric thinking with regards to the mental health landscape. Despite decades since the implementation of deinstitutionalisation, knowledge on rural mental health remains limited. This research lacuna is important to acknowledge given the many implications. Available evidence shows that service users perceive rural places as sites of inclusion and exclusion. What this points to, therefore, is the need for more exploratory work that can illumine ways to maximise the former. Rural places are complex and, indeed, this is reflected by the empirical challenge presented when attempting to compare across rural communities. This is important to note, not only in terms of disrupting notions of a 'rural idyll' but also as a way to highlight the exerting influence of history and localised cultural norms on senses of identity (particularly in the Highlands of Scotland) and the implications of that for those with mental health problems.

The evidence presented in this report also shows that the pandemic has disproportionately affected some groups more than others and, importantly, exacerbated existing inequalities. Whilst a full understanding of the effect of COVID-19 is still at an early stage, the evidence suggests more needs to be done to support both existing service users and overall population wide wellbeing. Despite its detrimental social and economic impact, as with any unforeseen change there are opportunities; in this instance, for encouraging a reconceptualisation of mental health. Specifically, the pandemic has shown how anyone's mental health can be affected, regardless of status or history. This increasing awareness has potential in terms of anti-stigma campaigns and for helping to bridge the gap between those with mental health problems and those without. Nevertheless, there is a pressing need to pay attention to the experiences of young people (particularly in rural areas) and how the pandemic has impacted them. Specifically, more mental health and wellbeing research is needed in order to understand what is helping young ones to feel well and what is hindering it.

The relationship between poverty and mental health is not new, and indeed it has a well-established history. Yet the point of its major focus in this report is timely given the significant and ever-increasing gap between rich and poor, essentially highlighting the need for a renewed focus. Much research on mental health does so in terms of promotion and prevention but few locate it within the wider economic framework that permeates the policy landscape and ultimately how that shapes personal lives; the evidence presented here shows why that is important. This report has covered a lot of ground in this regard and has specifically included the neo-liberal framework given that it accelerated many inequalities in the UK with its inception under Margaret Thatcher's government in the 1970s. In relation to mental health, the slow dismantling of social protections and the promotion of individualism above all else is concerning. More generally, the impact of increasing competition and the reification of market forces has had a significant psychological impact for all of us. As repeatedly pointed to in this report, the most

vulnerable bear the brunt. The work of Wilkinson and Pickett clearly shows that the encouragement of judgement of those who are seen as 'different', or of those who do not live in the right area, or who do not wear the right clothes, or speak in the right way, has had such a deleterious impact on human psychology, on community cohesion and on overall social connection: in short, people are increasingly withdrawing due to fear of the social evaluations of others. When this dynamic is applied to those already vulnerable to exclusion, it is clear to see the problem. The proposition here is that we need to move away from tokenism and small incremental change i.e. small pots of money in order to 'do something', instead policymakers need to ask 'how can we continue to change the narrative on mental health to address stigma and discrimination?', 'how are we really prioritising wellbeing so that policy aspirations and reality cohere?', 'how are we helping people to get out of poverty for the long-term?', 'are we investing enough to support the vital work of third sector organisations?'. The evidence in this report suggests we are more addicted, more depressed and more socially isolated that ever before; this social atomisation has consequences for all of us. To this end, the state needs to do far more because the neoliberal project has failed significant numbers of people, particularly the most vulnerable in our society. We need viable solutions for both service users and for overall population wellbeing, and we need more resources to be allocated in order to do that. Scotland has a real opportunity here in terms of the political landscape: the opportunity is to stand out and be an example of meaningful change that really does put mental health and wellbeing at the centre, where it belongs.

8.

Key Recommendations

8. Key Recommendations:

1. Issue: Stigma remains an ongoing issue

Recommendation: More qualitative research is needed to understand the impact of stigma, and to explore strategies that are used to negate it. Specific groups include women, people living with severe mental illness, those who identify as LGBT+, those with additional disabilities, middle-aged service users and migrants/refugees.

2. Issue: Limited crisis support

Recommendation: The issue of crisis support provision across the UK is concerning. More research is needed here, across multiple sites, to understand the impact from both service user and service provider perspectives. Such research is crucial to inform policy and to identify appropriate and sustainable solutions.

3. Issue: Limited knowledge on rural mental health

Recommendation: More research is needed generally on rural mental health but also specifically to understand the processes of inclusion and exclusion (and a more detailed look at gendered dimensions), as a way to inform policies that maximise the former.

4. Issue: COVID-19 has widened inequalities in mental health across gender and age groups, and exacerbated pre-existing inequalities.

Recommendation: More qualitative research is needed to understand the impact of COVID-19 on young people, women, and existing service users – in order to inform long-term interventions that are effective and context-specific.

5. **Issue: COVID-19 has been challenging for rural marginalised communities**

Recommendation: To continue to build on the current evidence base with more in-depth work within each of these communities. Additionally, research exploring mental health and wellbeing specific digital technologies as part of a viable solution to lockdowns, social distancing and remote engagement is recommended.

6. **Issue: Poverty remains one of the most significant social determinants of health and mental health**

Recommendation: given the increasing levels of poverty, research is needed to evaluate the most effective and sustainable solutions that can help individuals and families find their way out of the 'poverty trap'. Interventions should prioritise human wellbeing and thriving as part of their aim; the type of work a person has is just as important to their wellbeing as simply having a job.

7. **Issue: The impact of poverty on mental health is not well evidenced in rural areas**

Recommendation: More qualitative work is needed to understand the impact of poverty and its influence on daily life for service users, how it shapes perceptions of rural community life and the ability to connect with others, and the degree of influence it has on accessing available services. Such evidence is key for informing policies that are appropriate and relevant within a rural context.

8. **Issue: Scotland has a serious problem with drugs and alcohol consumption**

Recommendation: innovative pilots modelled on international case studies may be helpful in this regard; in particular, therapeutic treatments that specifically deal with the role of trauma in addiction should be considered, and trauma-based therapy should be made freely available, particularly in communities with higher

rates of addiction. Additionally, more financial support should be provided to organisations that are focused on building social capital and helping those recovering from addiction to build their connections within communities.

9. **Issue: Living in deprived areas leads to significantly worse mental and physical outcomes, including shorter life expectancy.**

Recommendation: More research is needed to understand the relationship between social and economic inequality, and its impact on mental and physical health. Concepts such as 'status anxiety' are particularly useful in this regard for exploring the experiences of those who live in deprived areas. Given the hidden nature of rural poverty, research in these geographical areas should be prioritised.

10. **Issue: The introduction of neoliberalism has led to significant wealth and income inequality which in turn has disproportionately affected the most vulnerable and disadvantaged, and impacted on overall wellbeing at societal level.**

Recommendation: more research is needed to understand the impact of neoliberalism, i.e. using the theory as part of the research framework, both for existing service users and for the general population.

11. **Issue: Neoliberalism has weakened the welfare state and invalidated the experience of mental ill-health.**

Recommendation: further qualitative research that captures the voices of those with lived experience is vital to ensure welfare planning remains true to its original intentions. Additionally, significantly more research is needed to hear from service users about the types of support interventions that could help them access better opportunities in terms of meaningful employment.

12. Issue: Covid has put significant pressure on charities in terms of their financial viability

Recommendation: Needs-assessments are vital to ensure that such organisations do not remain 'at risk' and are supported in their long-term planning to achieve sustainability.

13. Issue: There is a limited knowledge base on the voluntary sector in rural areas

Recommendation: More research is needed to explore the impact and contribution that the sector plays in rural areas, particularly with regards to mental health.

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