The geography of mental health

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INTRODUCTION

This Editorial takes a social science perspective of the geography of mental health, drawing upon the work of professional geographers with an interest in mental health and mental health care service provision. The academic discipline of Geography is broadly defined as "the study of the earth's surface as the space within which the human population lives" (Haggett, 1990). This all-inclusive definition, which basically includes everything that occurs both in the natural and human world, often results in the allegation that professional geographers are basically 'jack of all trades, and master of none!' However, in this Editorial I aim to demonstrate that geographers actually have much to offer to mental health research, both in terms of their social science research expertise and their particular 'geographical' view of the world. I hope to illustrate the benefits of including a geographical perspective in mental health services research to assist us in studying both the spatial patterns of mental ill-health, and the geographical distribution of mental health services and facilities at different spatial scales (local, regional, national, global).

Geographers (myself included) believe that 'Geography matters' when we ask research questions such as

'Why is there a concentration of people with mental health problems living in this district of City A'? or 'Why does Client A living in City A have access to services X, Y and Z, but Client B living in City B only has access to service Z'? Rather than simply observing spatial patterns, geographers seek to explore and interrelate the epidemiological, demographic, social, economic, political and spatial relationships which underpin phenomenon such as changing patterns of psychiatric service use or the variations in service provision in different places. This skill is derived from our 'jack of all trades' quality - we have been trained in all the above mentioned spheres, and thus can think very broadly about complex and interrelated factors when we focus upon a particular topic such as mental health.

Firstly I will briefly outline the development of mental health geography. I will then focus upon the research area of the geography of mental health care provision, using the findings of a doctoral research study (Jones, 1999) to demonstrate the huge potential of studying mental health service provision through a 'geographical lens'.

THE GEOGRAPHY OF MENTAL HEALTH

Within the discipline of geography, research on the geography of mental health constitutes a small sub-field, crossing the interests of a number of the sub-disciplines, most notably social and medical geography. For purposes of definition, social geography is concerned with studying social relations in space, and the spatial struc-

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tures that underpin those relations. For example, this involves an interest in the location of social groups in different places, such as the residential concentration of ethnic minority populations, low income families, or people with mental health problems within particular urban settings. Social geography is also concerned with mapping and interpreting the spatial incidence of social problems, for example: the geographies of crime; housing; health; education provision; drug and alcohol abuse; homelessness; and suicide (Jackson, 1994).

Traditionally, medical geography has had two broad areas of research concern. The research area with a longer tradition concerns the spatial ecology of disease and geographical aspects of health and ill-health. Some of the earliest studies in medical geography studied morbidity and mortality by examining their distribution in space, often by mapping them and comparing their occurrence in different geographical areas (Curtis, 1994). This ecological strand of medical geography is closely associated to studies in epidemiology, and has developed over the years to analyse the spatial distribution of illness and disease and associated environmental factors, for example the relationship between nuclear power stations and childhood leukaemia (Openshaw *et al.*, 1988).

The initial interest in mental health by geographers was through an ecological approach, drawing upon the work of Faris & Dunham (1939) who examined the distribution of patients admitted to mental hospitals in Chicago in the 1930s. Early geographical studies of the distribution of mental illness have included work by Giggs (1973; 1986; 1988) conducted in Nottingham, Taylor (1974, cited by Scobie, 1989) in Southampton, and Dean & James (1981; 1984) in Plymouth (all cities in England). These studies focused upon the relationship between mental illness and the urban environment, with particular attention to the spatial distribution of mental illness in different social areas of these cities. Some consistent findings of these studies have included: a concentration of people with schizophrenia in inner-city areas (Giggs, 1973; 1986; 1988; Dean & James, 1981); a more random distribution of people with manic depression (Dean & James, 1984; Taylor, 1974); and a correlation of incidence of particular disorders with social factors such as suicide and delinquency (Bagley *et al.*, 1973; Bagley & Jacobson, 1976). These examples of ecological studies of mental illness demonstrate the spatial variability of mental illness, particularly within an individual city.

However, as noted by Scobie (1989), there are a number of limitations of these types of ecological studies. A major difficulty is the fact that most research of this kind relies on data relating to service use, frequently inpatient statistics. Consequently such studies are not specifically studies of morbidity, but of service use. These studies also focus upon more severe psychiatric disorders and thus little is known about the geographical distribution of more minor (but still significant) disorders. Nevertheless, the ecological approach does provide researchers with a greater awareness of where people with more serious mental health problems live, and where local service provision needs to be targeted. This information is a crucial 'starting point' to then examine mental health policy issues such as accessibility to services and the provision of a 'needs-based' mental health service.

The geographical approach to studying incidences of mental illness has been built upon by more recent studies which have incorporated the significance of social and spatial processes to both the position of people with mental health problems within the urban environment and the facilities which serve them. The implementation of mental health reforms in Europe and North America since the late 1950s has created new areas of geographical interest, with people and services being transferred from institutional to community-based care. Geographers have an academic interest in the social and spatial processes involved with deinstitutionalisation, and this interest has provided the impetus for the emergence of a second strand of the geography of mental health - the study of mental health care provision.

GEOGRAPHICAL STUDIES OF MENTAL HEALTH CARE PROVISION

Since the 1980s the changing social context of mental health care provision, with the closure of long-stay psychiatric hospitals and transfer of people and services into community settings, has shifted the attention of many geographers to the impact of this significant social and spatial change. The first geographical studies regarding the geographical impact of deinstitutionalisation were conducted in North America. The pace of deinstitutionalisation has been quicker in North America than elsewhere and this is a contributory factor to why North American studies have dominated this sub-field. A key finding of these studies is the tendency for mental health facilities to become geographically concentrated in low income, inner city communities in major cities, for example in Toronto, San Francisco and Winnipeg (Dear & Taylor, 1982; Dear & Wolch, 1987; Currie *et al.*, 1989). These studies suggest that a ghettoisation of the mentally ill has developed in these places and that the isolation of the asylum is in danger of being replaced by an 'asylum without walls' (Wolpert *et al.*, 1975).

Until recently very few studies of mental health service provision have been conducted outside North America. In Britain, three studies were conducted at the end of the 1980s and early 1990s. Eyles (1986) investigated the provision and location of mental health facilities in Northampton and Giggs (1990) conducted research with a similar focus in Nottingham. Moon (1988) published a study which examined local community reactions to a mental health facility in Portsmouth. These three studies all substantiated the findings of North American research, finding a geographical concentration of mental health care facilities within less affluent areas of the respective cities.

In the 1990s, it has been researchers from mainly outside North America who have taken the lead in the exploration of different geographies of mental health care provision. A renewed interest in the concepts of space and place in human geography (Johnston, 1991) has been an important influence upon this new work, resulting in an emphasis upon the influence of the local context on the geographies of community-based mental health provision. Research studies conducted in New Zealand (Joseph & Kearns, 1996; Gleeson *et al.*, 1998; Kearns, 1998; Kearns & Joseph, 2000) and Britain (Milligan, 1996; 2000) focus upon the relationship between mental health care service provision and place. A key theme running through these studies is that the characteristics of particular places play an important role in shaping the local experience of deinstitutionalisation, both in terms of the local service delivery infrastructure and the experiences of the service users/clients of those services.

An important finding from the work of Milligan (1996; 2000) is that that the North American experience of the ghettoisation of people with mental health problems in inner cities is not necessarily a universal experience of deinstitutionalisation. Milligan found that the process of deinstitutionalisation in the localities of Dumfries and Galloway (Scotland), was not resulting in a major drift of people with mental health problems and mental health care facilities towards the inner city locations. Although she did find that many people travelled on a daily basis to these locations in search of social support.

Despite a renewed attention to the geography of mental health in the 1990s, there remains a deficit of studies which focus upon geographies of mental health services and facilities (Philo, 1997), and also which give attention to the experience of deinstitutionalisation in Europe. A recently completed doctoral research study (Jones, 1999) has aimed to address these two issues and also to take the research one step further by comparing the experiences of deinstitutionalisation in two different European countries in the form of a cross-national comparison. This study will now be briefly discussed.

COMMUNITY-BASED MENTAL HEALTH CARE PROVISION IN BRITAIN AND ITALY - A CROSS-NATIONAL COMPARATIVE STUDY

This doctoral research study sought to explore the temporal and spatial developments of the geographies of deinstitutionalisation in Britain and Italy since 1950, with particular attention given to the outcomes of national mental health reforms at the local scale. The geographical 'outcomes' investigated by this research were the extent to which psychiatric hospitals had closed and alternative community-based facilities had been established, as alternative service provision for people with mental health problems. Working within a cross-national framework, the research adopted a sensitivity to the role of place by exploring the social and spatial restructuring of mental health care service provision in two localities - Sheffield (Britain) and Verona (Italy). (For an explanation of why these two cities were selected as case study localities see Jones (1999; 2000). The purpose of focusing attention on these two cities, one from each country, was to explore the contention that to examine a locality provides a 'lens' through which one can explore the extent of implementation of national policies at the local scale.

The research was conducted at two spatial levels of analysis, with the fieldwork component carried out in 1994. At the national level, the formulation and implementation of national social policy and mental health legislation in Britain and Italy between 1950 and 1994 was examined to provide the contextual detail to the implementation of the respective national reform programmes (see Jones, 1999; 2000). The second level of analysis examined the spatial patterns of mental health service delivery in the cities of Sheffield and Verona. In considering the temporal and spatial impacts of deinstitutionalisation in the two localities, service provision maps, which showed the locations of community-based mental health care facilities, were compiled. The purpose of the service provision maps was to display the 'objective' geographical outcomes of deinstitutionalisation, i.e. the locations of former long-stay psychiatric hospitals and the locations of new community-based mental health facilities. To explore the decision-making process behind the locations of new community-based mental health care facilities, semi-structured interviews with mental health professionals and professional planners were conducted

(fifteen interviews in Sheffield and seventeen in Verona). The interview material provided explanations of existing spatial patterns of static mental health care facilities in the two localities, and also revealed how national policy was impacting upon local strategies for the planning and development of further facilities and services.

It is not possible in this Editorial to discuss all the research findings from this study, and interested readers can consult a more detailed publication (Jones, 2000). A finding of relevance to this Editorial is the huge diversity in the local geographies of mental health services and facilities that were found in Sheffield and Verona. A diversity exists despite the fact that both Britain and Italy have introduced broadly similar mental health care reforms: closing psychiatric hospitals and introducing community-based mental health care provision. In addition to international variations, there also existed intra-regional and intra-city differences, which were particularly pronounced in Italy.

The geographical variations in the provision of community-based mental health care in different parts of Italy are well documented (Tansella *et al.*, 1987; Donnelly, 1992; De Salvia & Barbato, 1993; Burti & Benson, 1996). An important finding from the research conducted in Verona was the wide variation in models of service delivery provided by the three different mental health services which operated within the city at the time of the research (1994). For mental health provision, the administrative district of Verona was divided into three geographical sectors in 1978 (when a new National Health Service was established and new mental health legislation (Law 180) was passed), according to the administrative boundaries of the city. Three new, separate mental health services were established and given responsibility for each of the three sectors.

In 1994 all services had an acute inpatient and outpatient service provided at two general hospitals. However, the community-based services and facilities being provided varied considerably across the city. Service A (in the south of the city) had developed a range of integrated services with a Community Mental Health Centre, which was open six days a week, and three multidisciplinary teams of mental health professionals who worked in the community, visiting people in their homes. There were also two community-based residential facilities. In Service B (in the north of the city) and Service C (in the centre and east) there were fewer 'static' mental health facilities. In Service B there was one residential facility. In Service C there were no residential facilities at all, although there were two co-operative workshops. Services B and C shared a day centre, located in

the centre of Verona, which served only young people. There was no day care provision for older people with mental health problems in these two sectors. Instead these two services provide ambulatories (a type of day surgery) in each local area, often in the local health centre, which people had to attend.

The implications of this wide variation in mental health service provision in the city Verona are clear: where people lived in the city determined the type of mental health care that was available to them. At the time of this research in 1994, Services B and C had not developed such a comprehensive range of community services as Service A. There seemed to be three main interrelated reasons for this situation. Firstly, the lack of co-ordination between the three different services at this time; secondly, the role of the local University's Department of Psychiatry in Service A; and thirdly, the role of particular mental health professionals in the development and management of the three local mental health care services. The roles played by these key professionals had been very influential in shaping the type of mental health provision available within the three geographical sectors between 1978 and 1994 (see Jones 1999; 2000 for a more detailed account).

The geographical variations in the mental health service provision within Verona are all the more striking when compared to the geography of mental health service provision in Sheffield. Unlike in Italy, where the National Health Service is responsible for providing mental health care services, in Britain the responsibility for mental health care service provision is split between the British National Health Service (NHS) and social services departments of local authorities. Although there are many complexities in this system, with different statutory and non-statutory agencies funding and providing mental health services in individual localities (see Wistow *et al.*, 1992; Mohan, 1996), there is a general principle that these different agencies will work collaboratively to provide services for a specific local population.

In Sheffield, the local health authority and social services department are responsible for co-ordinating mental health service provision across the whole city. In 1986 there was a spatial division of the city into five geographical sectors for mental health service provision, based upon administrative boundaries. However, this process of spatial sectorisation had a very different geographical outcome in Sheffield compared to Verona. Firstly, the same city-wide agencies had responsibility for service provision across the five sectors. Secondly, the spatial restructuring of the city had actually resulted in a greater spatial dispersion of mental health facilities

across the city between 1986 and 1994. This outcome is viewed as a result of a city-wide strategy to provide a spectrum of services within each geographical sector - inpatient, outpatient, residential and day provision and sector-based community mental health teams - reflecting the principles of national mental health policy. In the city there were also specialist mental health services that were available to people irrespective of which sector they lived in.

From the Verona case study, it may be asserted that the development of three quite distinct mental health services in the city was enabled by the considerable autonomy experienced by the mental health professionals managing the services. A freedom from externally imposed policy specifications or guidelines provided an opportunity for mental health professionals to implement their own interpretation of Law 180 within their respective sector. This level of autonomy at the local level of mental health care provision was quite different to the situation experienced by local service providers in Sheffield, where there was far greater centralised control from national and local policy requirements. At first sight, it could be perceived that the existence of sector-based services in both Sheffield and Verona is a similarity, both arising as a result of a decentralisation of service provision. However, in reality this represents an outcome of different political and organisational approaches to locality-based service provision, a consequence of different national-local power relations within the respective national political and administrative systems. This is an important finding which is only uncovered when one explores the process of implementation at the local scale.

From a cross-national perspective, comparing the local geographies of mental health provision in Sheffield and Verona has unravelled the 'detail' of variation and difference in the respective service delivery systems that might not have appeared so obvious in a single-nation study. This research has highlighted the fact that there are many insights to be gained by comparing mental health care reforms at different spatial scales - international, national and local. Such a research strategy can provide a unique opportunity to identify and illuminate similarities and differences between national experiences of mental health care reform. Research findings can be of particular value to policy makers, providing examples and ideas of innovative practices from different countries that may be transferable. There are also lessons to be learnt from aspects of different reform movements that have been less successful (Jones, 1996). For example, there are aspects of the Italian reforms that have implications for the organisation of community psychiatry

everywhere. An absence of political and administrative commitment to policy reform clearly hinders the effective nation-wide implementation of community-based mental health care. However, there are also examples of real innovation from the 'Italian experience' which can be adopted from one country to another (Tansella, 1991). It is considered that the possibilities, both in terms of research and policy, derived from adopting a cross-national perspective are considerable and worthy of further attention.

CONCLUSION

Huxley (2001) has commented that social scientists have much to offer to mental health services research and development. In this Editorial I have attempted to demonstrate that one particular group of social scientists, professional geographers, have a range of research interests and expertise that can make a significant contribution to mental health research. Geographers, with their broadness of knowledge about the world in which we live, as well as their expertise in 'thinking geographically' about research problems, have much to offer to the mental health research and policy arenas. It is suggested that Geographers' contribution to this field can be maximised through greater collaboration between mental health professionals, researchers and other social scientists, with all the disciplines bringing their specific expertise to the 'research table'.

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