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Occupying Space: Mental Health Geography and Global Directions

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Is there any worth in living? Live not for our own purpose. Instead of being arranged like rabbits, it is better to die. It seems that we are just occupying space (Rupa as quoted in Jadhav and Barua 2012, p. 1361, author's emphasis). This extract comes from the clinical assessment of a 'sad young lady' from Assam in northeast India, diagnosed with dysthymia. After losing her husband in an elephant attack, Rupa has experienced a range of difficulties, including sleep problems, panic attacks and a deep sense of foreboding leading her to feel hopeless and humiliated about her mental health condition and fearful about her future (Jadhav and Barua 2012, p. 1361). These individual concerns of stigmatization and fear coincide with broader apprehension over treatment and confinement of individuals experiencing mental health problems, and are symbolic of a wider conceptualization of mental health and its spaces. Many academic disciplines, such as sociology, history of medicine, critical psychiatry, history, psychology, transcultural psychiatry and geography, have grappled with the different ways in which difference, in relation to 'madness', has been configured as mental illness and traced through a range of sites and spaces across the globe (see Porter 1987; Philo 2004; White and Sashidharan 2014). Many of these pieces have been informed by the work of French theorist Michel Foucault (1967, 2006, see also Philo 1992), who, as Parr (2008, pp. 3–4) has noted, 'outlined a specifically spatial impulse in the historical disciplining of Unreason (as madness) by Reason' in his attentiveness to the

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spatial relations involved in separating and segregating individuals labelled with mental health problems in society. The impulse was arguably productive of a nuanced governmentality which was itself anchored in the development of a specialist science of the so-called mad mind. This emergence of psychiatry developed in a range of specific scientific sites, spaces and places, such as asylums, madhouses and hospitals, and this constricting web of governmentality arguably allowed the legitimization of psychiatric theory and practice through these spaces (see Parr 2008, pp. 1–30; Philo 2012).

There is therefore, undoubtedly, a complex geography to mental health (see Philo 2004, 2005). The geographies of mental health can comprise a number of elements, including the variations in incidences of mental ill-health, the range of locations occupied by the variety of institutions and facilities designed to diagnose and treat individuals experiencing mental health problems, and the different environmental components employed in the creation of therapeutic regimes for those experiencing mental ill-health (Philo 2005). For example, a range of spatial dimensions can be considered through a geographical lens. From the complex inner workings of the mind of individuals to a range of bodies experiencing and treating mental health problems that weave in and throughout medical and non-medical landscapes, geographers have attempted to chart the use and construction of these varied landscapes. The global corporate pharmaceutical machines that ensnare local general practitioner (GP) practices and hospitals in their webs are considered alongside the political action that sweeps across international borders. This fixing and asserting the position of mental health in global agendas and public discourse are simply a few of the spaces that comprise the complex geography of mental (ill-)health. This chapter seeks to highlight the significance of thinking geographically about mental health in a range of ways and aims to demonstrate what a geographically informed analysis of mental health can offer to future debates within global mental health. Beginning with an overview of mental health geography, this chapter will then focus upon four interconnecting strands of the subfield, that of 'spatial epidemiologies' and the 'psychiatric city', provision and the complex spaces of care, and therapeutic landscapes, to highlight the significance of a geographical approach. A range of examples from the work in mental health geography and beyond will be used to illustrate the different geographical components revealed by these studies, and possible connections of this work to future engagements with mental health geography beyond the Global North will be highlighted. Finally, future challenges and agendas for further critical exploration into global mental health from this perspective will be suggested, particularly in reference to the lack of attention currently given to those sites, spaces and voices in the Global South.

Mental Health Geography

The concerns of 'mental health geography', a subfield of the discipline that takes as its focus the spatial and place-related implications of both the experience of mental ill-health and the provision of treatment facilities and programmes (see Philo 2001), have intersected with the interests of a number of other subfields such as 'health', 'medical', 'cultural' and 'social' geography. Mental illness, its diagnosis and treatment are widely reflected in the literature as an issue that permeates through a range of social, cultural, political, health and medical spheres, and current policy debates relating to the Global South are beginning to consider the places where these spheres overlap in more depth (e.g. WHO 2013). Terminology in such discussions is highly significant as while some geographers remain content to deploy the models and terms of 'mental illness', others prefer to remain sceptical about conventional medical-psychiatric models and seek alternative ways of understanding the wide range of experiences felt by people with mental health problems (see Parr 2008). In doing so, a number of theoretical frameworks have been adopted, including insights from 'anti-psychiatry' (Spandler 2009) and 'post-psychiatry' (Bracken and Thomas 2001), and utilizing a wide range of conceptual vocabularies from phenomenology, critical social theory, psychoanalysis, psychotherapy and political economy (e.g. see McGeachan 2014; Laws 2011). In part to connect with the ongoing attempts to reclaim 'madness' as a politicized identity such as in the recent case of the 'voice-hearing' movement (see Callard 2014), a number of geographers have elected to speak of 'madness' rather than 'mental illness'. Adoption of this term is also partly to acknowledge that as Philo (2005) has highlighted, 'madness' has historically been the predominant mode of understanding different forms of mental difference across different parts of the globe.

In their substantial review, Wolch and Philo (2000) chart three 'waves' of inquiry in mental health geography which are inherently connected to some of the key moves in the discipline of human geography. The first 'wave', the authors suggest, was grounded in spatial science and often employed quantitative methods to investigate the distribution of 'deviant' populations including those experiencing diagnosable mental illnesses. The second 'wave', in contrast, utilized more qualitative methods and remained rooted in social theory, centred more firmly on the social construction of difference. Trajectories towards a third 'wave' are suggested by the authors as harnessing a range of theories and methods to uncover a more nuanced understanding of 'place-specific happenings' alongside more structurally determined 'space-compressing' processes (Wolch and Philo 2000, p. 149). This, the authors

note, requires an ability to conduct research across scales, from the micro-scale of individuals' experiences to the macro-scale of external restructuring of corporations and industries. Interestingly, much of the research conducted in mental health geography remains within the confines of the Global North, although this is beginning to be challenged in part due to the increased attention given by the World Health Organization (WHO) and other global organizations to the mental health agenda (see WHO 2001, 2013; Curtis 2010). This absence of research within the Global South in the subfield is both notable and arguably concerning. Through the threads of 'spatial epidemiologies' and the 'psychiatric city', provision and the complex spaces of care, and therapeutic landscapes, the following sections will illuminate the significance of a geographical approach to viewing mental health and signal a way forward for the inclusion of a host of experiences and voices from the Global South currently absent from the literature in the field.

'Spatial Epidemiologies' and the 'Psychiatric City'

Currently, over half of the world's population (54 per cent) live in urban areas with many of the world's largest cities now located in the Global South (UN 2014). This significant spatial reordering of the world's population, which is predicted to continue in this trend (UN 2014), signifies the importance of considering the complex geographies of these spaces. Many urban health scholars are at present debating the current priorities for research into these areas for as Harpham (2009, p. 113) notes 'cities in the South have some of the most striking inequalities in the world: cheek by jowl slums and areas of affluence'. Alongside concerns over physical health in these diverse urban spaces, mental health in the urban areas of the Global North has received considerable attention by mental health geographers (see Curtis 2004, Chap. 7). Throughout the early 1960s and inspired by the pioneering work of sociologists Faris and Dunham (1939) on 'mental disorders' in the city and their influential map of schizophrenia in Chicago, a number of geographers began to reconstruct what can be termed the 'psychiatric geography' of the city (see Wolch and Philo 2000, 139; Nutter and Thomas 1990; Giggs 1973). Many of these studies used a number of statistical methods to detect cross-correlations with spatially referenced data on other variables such as population densities and housing conditions to establish possible causal influences. A key text in this vein was a study by Giggs (1973) on the spatial variations in the distribution of schizophrenia within Nottingham which highlighted a number of close correlations between the incidence of

schizophrenia and a large number of social and urban environmental factors such as low social status, high unemployment and low social mobility. This set of work relating to the 'spatial ecology' or 'spatial epidemiology' of diagnosed mental illnesses (see Giggs 1988; Wolch and Philo 2000, 139) produced an interesting array of findings about inner-city concentrations of particular medicalized groupings (especially of schizophrenia) and their socio-economic correlates. Many of these studies paid close attention to the economic factors that aided in shaping many individuals life circumstances to explore the socio-epidemiological correlation between poor mental health and poverty (Murali and Oyebode 2004). However, many studies were careful not to attribute causation exclusively to one factor alone, noting the complexities of interpreting such a nuanced set of conditions (Giggs 1973). This relates strongly to the broader debates surrounding the social construction theory and social drift theory, which continue to investigate and debate socio-economic conditions, urbanization and mental illness (see Hudson 2012). The previous studies tended also, in general, to confirm the earlier findings of Faris and Dunham (1939) with respect to schizophrenia that demonstrated a clear distance decay in the prevalence of schizophrenia with increasing distances away from the city centre, highlighting the significance of these urban spaces for such investigations.

The quantitative rigour of such studies, for example, Gigg's use of factor analysis, offers an elaborate way of describing spatial patterns and cross-correlations. For example, the work of Joseph and Hall (1985) into the concentration of social service facilities, including psychiatric group homes, applied a location quotient analysis to such services in Metropolitan Toronto. The authors argue that the localization data collected could be used in the formulation of placement policies to achieve a more equitable distribution of services. However, despite the detailed spatial patterns produced by the work, such studies do not necessarily succeed in explaining in any great detail the causal mechanisms involved in generating such patterns. Other geographers have therefore attempted to develop their understanding of a city's psychiatric geographies. A range of studies has emerged since the 1980s that investigates the micro level of individuals, many discharged patients or never-institutionalized people, and their interactions with different treatment spaces and landscapes. The use of the urban environment and its role as a source of 'quality of life', 'stability' and 'contentment' was considered (see Smith et al. 1993, 1994) with specific aspects of urban living, such as poor quality and lack of affordable housing, being discussed as a 'stressor' effect on people suffering from enduring mental ill-health (see Kearns and Smith 1993; Kearns et al. 1992).

As the process of global urbanization continues to operate, with all regions expected to urbanize over the coming decades and with Africa and Asia projected to do so faster than all other regions, becoming 56 and 64 per cent urban, respectively, by 2050 (UN 2014), lessons from many of these geographical studies into the 'psychiatric city' can become increasingly valuable. Significant attention in these studies has focused on the correlations between socio-economic indicators such as poverty and geographical indicators of population mental illness (Curtis 2004, pp. 206–207). As the scale of urban poverty is arguably being increasingly overlooked (Satterthwaite and Mitlin 2013), a renewed concentration on these indicators and their correlations could trigger new multi-scalar discussions. Much of the work detailed in this section informed public policy on facility location allocation in relation to mental health in these areas (see Philo 1997, pp. 76–77) and although these models can be highly problematized, particularly in relation to the nature of the services provided, they do shine an interesting lens on the creation and delivery of mental health services in urban areas. As highlighted in the work of Hudson and Soskolne (2012) on their discussions of the disparity on the geography of serious mental illness in Israel, the last decade has witnessed a range of developments in the study of local prevalence rates in mental illness. For example, 28 nations as part of the World Health Initiative have undertaken parallel national psychiatric epidemiological surveys using the WHO Composite International Diagnostic Inventory (WHO-CIDI) (Hudson and Soskolne 2012, p. 898). These studies seek to inform service planning and funding at local levels in order to target resources but, as Wolsh and Philo (2000, p. 149) stress, serious critical consideration must be given to engagement with the policy arena in order to carefully understand the possibilities of the use and misuse of research findings in these debates. For example, many studies have questioned, in different ways the representativeness and cross-cultural validity of the CIDI and other epidemiological evidence, such as the disability-adjusted life year (DALY) measurement. Brhlikova et al. (2011) discuss the serious consequences of uncritically applying epidemiological data in terms of international health care policy making and in reference to depression rates stress that 'single composite measures of depression are highly problematic: they conceal and hide uncertainty, compromise biases and distortion in epidemiological data' (32). This can lead to already scarce resources being diverted and the cultural and social significance of mental health conditions such as depression being hidden and ignored. Laurie (2015) pushes these warnings further in her critique of the DALY measurement, suggesting that the management of human bodies and human suffering is tied ever so closely with economic management and that 'DALY's are complicit in devaluing the

lives of certain individuals, by asserting the values of individualism in relation to wider economic gain' (85). The uses and abuses of data in this vein should be continually highlighted and acute attention paid to the policy impacts on people over space and time. Also, there must be increased awareness to see individuals as more than simply 'service users' but as people making difficult decisions in this changing global care climate.

Provision and the Complex Spaces of Care

While concern over where service need is higher in certain places in relation to specific mental health disorders raises important questions about diagnosis and location, a further area of concern in the geographical literature focuses on the tensions and contradictions in attitudes and beliefs towards mental ill-health that can be revealed through an historical analysis of the spaces of care for mentally ill individuals. Often referred to as 'asylum geographies' (Wolch and Philo 2000, 138), which broadly refers to studies concerned with investigating the geographies of mental health services, attention has been given to the origins of mental health care facilities in the 'lunatic asylums' that appeared across Western countries. The asylum often remains a concrete symbol in the landscape of mental health provision and care. For Philo (2014a, n.p.),

> They [asylums] speak of grand medical and moral visions about cure and kindness, albeit a high ground not always reached in practice, and hence they also speak of incarceration, loneliness, abuse and despair. They are painful windows into the soul of a past social order, illuminating what the experts of the time understood to be the divisions between the 'sane' and the 'insane', 'reason' and 'madness', those to be welcomed and those to be shunned.

Arguably, acute attention to the space(s) of the asylum can cast light on the complex geographies of madness and societal responses to it (see Philo 2004). A number of geographers have used various archival sources to reconstruct the location adopted by asylums and hospitals run by a number of (state controlled) bodies and institutions (see Ross 2014). A key body of work in this respect is Philo's (see 2004, 1997, 1989) detailed investigations into 'the spaces reserved for insanity'. Much of Philo's work traces the changing geography of places and spaces associated with madness in Britain through the eighteenth and nineteenth centuries, paying particular attention to the discourses and practices that have created a succession of overlain and often disputed 'landscapes of lunacy' (2004). Questions raised in this type of work address

the extent to which such locations—the specific spaces and environments—were shaped by medical, moral or economic discourses, or by a deeper sense of wishing to remove certain 'troubling' and 'frightening' populations from 'sight and mind'. Many of these arguments have been debated in reference to a large number of similar institutions, not specifically designed to house and treat those with mental health problems but which inevitably become bound up with such individuals (Moran 2015). For example, Disney (2015) in his discussions of the complex spaces of orphan care in Russia highlights the range of mental health issues that arise in such spaces and the varied nature of care that is provided.

Attention has also turned to the often abandoned asylum sites themselves. Research has shown the deeply symbolic value still placed on these sites by patients, workers and communities long after the closure of the facility itself. Studies have demonstrated some of the aftermaths of the closure of certain long-stay facilities. Through detailed qualitative work, the significance of old hospital buildings and their surrounding sites has been highlighted (Kearns et al. 2012). In their discussions of patient and staff memories and narratives from the now closed asylum of Craig Dunain in the Scottish Highlands, Parr et al. (2003) highlight the contested nature of such asylum spaces. Their study highlights the notion that these asylums should be considered as more than simply places of medical intervention and treatment, and instead be considered as 'complicated social geographies, heavily invested with symbolic and emotional meanings evoked through the material practices of giving and receiving care' (343; see also Gesler and Kearns 2002). Important connections can be drawn here with work conducted on the design and implementation of contemporary psychiatric care settings in the so-called post-asylum landscape (Wolch and Philo 2000; Curtis 2004). For example, through their research into the perceptions of a newly built psychiatric unit in London, Curtis and colleagues (2009) argue that important questions are raised in these newly restructured landscapes of care as the 'clinical space' is now extended into the community. They discuss the tensions and situations that arise for psychiatric patients and staff when such 'new spaces of [inpatient] care' are being produced, formed and utilized (Curtis et al. 2009) in today's 'risk society' (Moon 2000).

Alongside these institutional spaces and their legacies, geographers have examined a wide assortment of care spaces in the community associated with the process of deinstitutionalization, such as out-patient clinics, support projects, counselling services and home spaces (see Parr 2008; Bondi and Fewell 2003; Bondi 2009). While some have expressed concerns about the sufficiency of such spaces in terms of numbers and quality of service, others have

questioned whether the new mechanisms, dispersed throughout diverse communities, amount to a tighter web of 'psychiatric influence' (see Wolch and Philo 2000, 141–143). Examples in this respect include, Dear and Taylor's (1982) Not on Our Street, and Dear and Wolch's (1987) Landscapes of Despair. Dear and Taylor's (1982) work sought to establish the nature, magnitude, and geography of community opposition in Toronto to proposed mental health facilities. In doing so they emphasized the challenges of many communities, notably middle-class suburbs, adopting a 'not-in-my-backyard' (NIMBYist) attitude towards mental health facilities and their users. In contrast, Dear and Wolch's (1987) study more broadly applies theoretical perspectives such as structural analysis and human agency to understand the downstream effects of asylum closure. They survey new spaces of poverty, drug abuse, homelessness, and even reinstitutionalization through the penal and care systems that reinstitutionalized and transinstitutional patients inhabit, such as sober-living homes and other small-scale facilities. A focus in these studies still remains on the urban with relatively little research being conducted on rural areas (for an exception, see Milligan 1999; Parr et al. 2004). Milligan (1999, pp. 234–236) notes that mental health requirements in certain rural populations are poorly understood and advocates a need to develop different typologies of the rural environment in order to aid understanding into the different factors impacting on rural-based individuals with mental ill-health.

A fixation on the differing spaces of care for individuals experiencing mental health problems in a broader changing (deinstitutional) landscape brings into sharper focus the uneven distribution of these health care resources and the fractious politics surrounding their use and implementation (see Curtis 2010; Almog et al. 2004). However, as Saraceno and Saxena (2002) highlight in their discussion of Project Atlas, launched by the WHO in 2000, there is a need to pay attention to the spatial and social subtleties of such agendas. In relation to legislative practices concerning mental health, the authors' note that although the majority of countries in Project Atlas have a law relating to mental health, this is often not comprehensive and 'does not adhere to the international legislation concerning human rights' and is most frequently 'simply mentioned as part of a general health law or a law related to forensic medicine' (Saraceno and Saxena 2002, p. 43). An example of asylum care in India reported in *The Lancet* in 2001 can acutely demonstrate the consequences of such general legislation and highlights the importance of giving such attention to the different spaces, site, and places of asylum care. Kumar (2001) discusses the devastating death of 27 patients that occurred in the village of Erwadi in the southern state of Tamil Nadu on August 6, 2001. In the privately run mental asylum, 27 people were burnt alive, including

11 women, who had been chained to rocks and pillars. The asylum had no electricity or basic sanitation and no doctor was allocated to care for the patients. This was 1 of the 17 similar institutions in the village (Kumar 2001, p. 569). The provision for mental health patients in India is alarmingly scarce, with projected estimates noting that only 100,000 beds are available but over two million are required (this being 2 per cent of the population) and most of these are most desperately needed in urban areas (Kumar 2001, p. 569; see also Davar 2014). This is not unusual as recent reports into mental health service provision in Uganda showed that the only mental health hospital in the country (Butabika National Hospital) had a total of 500 beds (1.83 beds per 100,000 population) (Kigozi et al. 2010). Attention to these asylum (and post-asylum) spaces at the micro (rooms, corridors and equipment), meso (buildings, grounds and fields) and macro (environmental, ecological and locational characteristics) scales (Philo 2014a) provides an important lens into the ways in which these spaces reflect the changing understandings and conceptualization of mental (ill) health across the globe and sheds light on the experiences of those individuals (patients, doctors, families and attendants) caught up within these spaces of care.

Therapeutic Landscapes

As Kearns and Moon (2002, p. 612) highlight in their discussions of a possible new geography of health, the awareness of place as 'an operational "living" construct which "matters" as opposed to being a passive "container" in which things are simply recorded' has an influential effect for discussing the social, political, cultural and historical geographies surrounding mental health and mental illness. In relation to health geography, the notion of landscape has arguably secured an enhanced awareness to 'the intersection of the cultural and the politico-economic in the development of place-specific landscapes of health care and health promotion' (Kearns and Moon 2002, p. 610). One aspect of this development relates to the notion of 'therapeutic landscapes' first introduced in the geography literature by Gesler (1991) in his text The Cultural Geography of Healthcare. Gesler (1993, p. 71) defined therapeutic landscapes as places with 'an enduring reputation for achieving physical, mental, and spiritual healing' and sought to use the concept to further understand interconnections between health, place and identity. Scholars have investigated the symbolic structure embedded within therapeutic landscapes, one of the most internationally prominent being that of the physicians' white coat (Gesler 1991). This coat, for Gesler (1991), has an array of symbolic

meanings for different people, such as representing status (economic), privilege and care, and is bound up in the sites and spaces of a variety of medical encounters from the doctor's surgery to the treatment centres in crisis zones. Jones and Moon (1993) argue that attention to therapeutic landscapes can shed new light on the locational and geometric approaches to space and place and in doing so bring to the fore new connections between health, ill-health and place, albeit in complex ways.

The range of landscapes that are tied up with these discussions varies greatly from 'natural and built physical landscapes, social and symbolic environments, and landscapes of the mind, that is, largely or entirely imagined landscapes' (Rose 2012, p. 1381). Although initially a therapeutic landscape was bound to traditional places with healing properties for specific populations, the concept has diversified to include a range of natural and built environments such as gardens (Milligan et al. 2004), public libraries (Brewster 2014) and respite centres (Conradson 2005), all demonstrating the assumption that such a setting can generate the necessary components for some kind of therapeutic experience (Rose 2012). However, within this critical dialogue between different settings of the therapeutic landscape emerges a body of literature that stresses the need to think about the 'counter-therapeutic' and 'non-therapeutic' landscape, the latter arguably perceived as more passive than the former (Jadhav and Barua 2012). In their study of the hidden mental health dimensions of human-elephant conflict, Jadhav and Barua (2012) argue that asymmetric interactions between elephants, people and institutions generate landscapes that are actively 'counter-therapeutic', integrating ecology, culture and the clinic. Important questions are raised here about the construction of therapeutic landscapes and by whom, revealing complex social-political dynamics around the ordering of space for different populations (see Massey 1994).

Wilson (2003), in her research into First Nation Peoples in North America, argues that the concept of therapeutic landscapes is very much:

> a Western conceptualization that does not allow for the incorporation of 'other' ways of viewing the link between health and place. (p. 84)

She notes that research into therapeutic landscapes often ignores the cultural specificity of these landscapes as focus tends to fall upon landscapes that are significant in Western cultures, such as spas and baths (Wilson 2003, p. 84). In her research into how therapeutic landscapes shape the everyday lives for people of the Anishinabek Nation living in Ontario Canada, she explores the importance of culture, for example, systems of belief, and in doing so, she

argues that geographical research on health for First Nation peoples can be improved (Wilson 2003, p. 91). For example, Wilson notes that the concept of health in Anishinabek culture is complex and moves beyond traditional biomedical models of health and this is highlighted through a discussion of the medicine wheel. The research stresses that the 'Anishinabek have conceptions of place that differ from our own' and therefore attention to therapeutic landscapes reveals 'the complex intersection of culture, identity and health as manifested in their daily geographies' (Wilson 2003, p. 91). Similarly, Phillips and Rosenberg (2000) argue that much of the work conducted through the lens of health geography tends to be an exercise in 'intellectual imperialism'. Stating that a significant proportion of the research focuses upon English-speaking countries and therefore little space is allowed for exploring how such theoretical arguments, such as therapeutic landscapes, can be applied in developing countries (Phillips and Rosenberg 2000, p. 376). Madge's (1998) work into the therapeutic landscapes of the Jola of The Gambia, demonstrates the important intersections between indigenous medicine and biomedicine and thus highlights the value of

> placing an understanding of health care systems in different places within an awareness of global power relations. (p. 293)

Through the case study of the health care system of the Jola, the author documents indigenous human and ethnoveterinary medical practices, particularly the role of herbal medicine, and highlights the significance of place and cultural context when investigating health care beliefs and practices (Madge 1998).

Gesler (1991, p. 8) argues that, in examinations of health and place, geographers must begin to focus on ethnicity and ethnomedical systems. Wilson (2003) pushes this further by suggesting that more could be done to move away from the continued focus on Western perceptions of health. Instead, researchers should 'acknowledge diversity, difference and the existence of multiple identities and their role in shaping health' (Wilson 2003, p. 85). These debates within the geographical literature relating to therapeutic landscapes cross over into the work of mental health geography. As highlighted in this section, a focus on therapeutic landscapes in these different guises can offer an important critique to the work conducted with mental health geography and open up new pathways of engagement with a range of voices, institutions and experiences bound up with mental health and mental illness that are currently absent in the literature. While work has very creatively used the concept of 'therapeutic landscapes' to discuss the mental health care landscape and different individuals' 'journey' through and within them (see Wood et al. 2013),

very little work within mental health geography centres specifically on places within the Global South and the range of people wrapped up in these landscapes. There are many possibilities, therefore, to take these approaches from health geography to the specifics of metal health care and mental health. The following section will offer some reflections on possible points of intersection between discussions of global (mental) health and mental health geographies and raise a number of questions for future consideration.

Discussion: Future Directions

A range of global mental health literature seeks to challenge the assumptions and politics of the current global mental health movement (Tribe 2014) and to seek out solutions in services that are sensitive to the sociocultural context to which they are applied (White and Sashidharan 2014). Jain and Jadhav (2008), in their critique of community psychiatry in India, reinforce the importance of developing culturally sensitive psychiatric theory and clinical services. The prominence of the local in a variety of ways is illuminated, demonstrating the reoccurring tensions between scales of knowledge and encounter. Questions arise over the emphasis placed on local values and concerns in developing mental health programmes and the 'place' of community and community values in designing and implementing appropriate spaces of care. This work correlates with a growing interest within transcultural psychiatry to the mutable nature of cultural identity within the clinical encounter (see Aggarwal 2012; Bonovitz 2005). Paying increased attention to how 'culture frames the self, other, and belief systems during therapy' (Aggarwal 2012, p. 134) brings to the fore the importance of considering a range of spaces, sites and landscapes bound up within the 'clinical encounter' in an increasingly globalized world.

In their report on medical tourism, Buzinde and Yarnal (2012, p. 784) discuss the possibilities of exploring the complex relationship between

> 'the places of human experience and health' through a postcolonial lens. In doing so, the authors' suggest that this would 'contribute to knowledge on the macro-spatial dynamics that characterize the complex core/periphery relationship entailed in the (re)production of therapeutic landscapes of care'. (Buzinde and Yarnal 2012, p. 785)

For many geographical scholars, working within the framework of postcolonial theory allows an investigation into the global politics of difference and

a critical examination of taken-for-granted knowledge systems (Briggs and Sharp 2004). In relation to (mental) health, this brings to the fore the complex relationship between 'scientific' medical practices and ways of knowing and indigenous knowledges and alternative forms of healing. Questions arise over the place given to alternative forms of being and of healing in the current international climate of adopting the Western 'scientific' model medicalization and 'cult of the expert'. What space is given to these 'non-scientific' and/or alternative discourses of mental health and mental illness in the construction of new global mental health policy and implementation? Many geographical studies, as demonstrated, are beginning to understand the complexities of asylum and post-asylum care but a global approach paves the way forward for attempting to understand the alternative spaces of care that are provided across a range of scales. For example, what can the micro-geographies of spiritual healing centres and the roles of traditional healers add to an understanding of the different spaces of mental health care? Can this level of analysis aid in bringing to light a whole range of community spaces largely hidden within the currently asylum and post-asylum discussion? Combining postcolonial approaches and therapeutic landscapes could therefore offer geographers and those working within global mental health the opportunity to understand more deeply transcultural spaces of mental health and mental illness.

An increasing body of work on contemporary global health governance has turned to focus upon the 'inequalities often born out of a biopolitical regime that is increasingly driven by the logic of profit and the pursuit of capital accumulation' (Laurie 2015, p. 75). Yet what becomes increasingly clear in these discussions, as noted by Laurie (2015, p. 76), is that the notion of global health can be seen as a misnomer (Heywood 2002, p. 218) as there is an increasingly awareness of the local and unequal articulations of such 'global' phenomena. Questions arise here about the possible sites of resistance and spaces for activism in the mental health area. These debates importantly include both mental health service users and those who wish to stay out of the medical and diagnostic systems. How do these discussions bind together or divide the local, state and 'mental health alliances'? The contentious debates surrounding the right to health strike right to the heart of the 'Global Mental Health' movement as it brings to the fore serious inequalities present over access to care in many countries in the Global South. For a number of scholars, accessing health care that can be seen to be culturally sensitive and locally relevant is key to mental health care in low-income countries (see Jadhav and Barua 2012). Payments for medication and travel to mental health services are increasingly reported to be a barrier in receiving care and are tied up with a series of complex local and societal geographies

of stigma and exclusion (Jadhav and Barua 2012). In many ways, '[w]hen health care ceases to be viewed as a public right and it is transformed into a commodity it begins to conjure different "images" to different populations' (Buzinde and Yarnal 2012, p. 785) and further attention can be paid to highlighting the different landscapes of care, healing and incarceration that are constructed in this vein.

Conclusions

As demonstrated through the range of approaches above, investigating the issues of mental health through a geographical lens opens up the possibilities for viewing individual experience of mental health problems as a multidimensional and multi-scalar issue. Returning to the opening quotation of this piece brings to the fore the people and their often painful experiences that are central to these global debates. Rupa may feel that she is simply occupying space, only existing and not living in the world around her, but lives such as Rupa's are never geographically static in nature but continuously cross-cutting into a range of material, social and symbolic worlds at a range of different scales. In increasingly 'insecure' times (see Philo 2014b), research in mental health geography is tightly bound to broader issues such as environmental change and global health. As a call to 'scale-up' mental health service provision and inquiry continues to dominate (see WHO mhGAP 2008), a geographical approach can work in conjunction with the debates in global mental health to highlight the nuances of such an inherently spatial strategy. For example, Curtis (2010, pp. 215–238) calls to geographers' attention the complex question of how mental health might be improved at the population level, placing particular attention on strategies to provide and promote good mental health in the population as a whole, as well as focusing upon treatment of individuals experiencing psychological distress. However, discussions within global mental health also pose a number of important challenges to current geographical research on mental health and mental health care. The current 'silence' of research case studies and work investigating those places that are outwith the confines of Western health care points to a wider failing of mental health geographers' engagement with the cultural specificities of health care and their practices in the Global South. As a range of powerful globalizing forces continue to significantly shape and reshape the places of the world, there is clearly much to be achieved by taking a geographical approach to mental health. However, geographers must also stay alert to the diverse range of spaces, places and people that require attention or there is a danger that the

voices and experiences of Rupa and others in the Global South will remain forever silent in the future narratives of mental health geography.

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