HOUSE OF COMMONS

Environment, Food and Rural Affairs Committee

Oral evidence: Rural mental health, HC 873

Tuesday 15 March 2022

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Watch the meeting

Members present: Neil Parish (Chair); Kirsty Blackman; Rosie Duffield; Barry Gardiner; Dr Neil Hudson; Robbie Moore; Julian Sturdy; Derek Thomas.

Questions 1 - 50

Witnesses

I: Sarah Hughes, Chief Executive, Centre for Mental Health; Dr Rebecca Wheeler, Senior Research Fellow, Centre for Rural Policy Research (CRPR), University of Exeter; Dr David Rose, Elizabeth Creak Associate Professor of Agricultural Innovation and Extension, University of Reading; Rachel Hutchings, Fellow in Health Policy, Nuffield Trust.

Written evidence from witnesses:

– Centre for Rural Policy Research (CRPR), University of Exeter

- University of Reading

- Nuffield Trust

Examination of witnesses

Witnesses: Sarah Hughes, Dr Rebecca Wheeler, Dr David Rose and Rachel Hutchings.

Q1 **Chair:** Welcome to the EFRA Committee. This afternoon we are looking at rural mental health. We are fortunate to have a panel of four very good academics who are going to tell us exactly how we move forward with this inquiry. Would you like to introduce yourselves?

Dr Wheeler: I am Rebecca Wheeler. I am a senior research fellow at the Centre for Rural Policy Research at the University of Exeter.

Dr Rose: I am David Rose, associate professor at the University of Reading.

Rachel Hutchings: I am Rachel Hutchings and I am a fellow at the Nuffield Trust.

Sarah Hughes: I am Sarah Hughes, chief exec at the Centre for Mental Health.

Q2 **Chair:** This is our first panel looking into this very sensitive issue, so today is very much to go through and ask you questions to scope, in a way, our further inquiry, so we appreciate you all coming in. In particular to Sarah and Rebecca, but you can all answer: how does the mental health of people in rural areas compare to that of people living in larger towns and cities?

Dr Wheeler: I am going to slightly twist the question in a way, in that the evidence from our research is specifically looking at farming, which is not necessarily down to a rural-urban divide. Within rural, there are also differences. From our research, we found that the farming community appears to have poorer levels of mental health compared to the general population.

For instance, we did a survey with the RABI and had over 15,000 responses. That included farmers, but also other members of farming families, other farmworkers and non-farming members of farm households. It showed that there were quite concerning levels of poor mental health across agriculture. Specifically, 36% were classified as possibly or probably depressed, and 47% were suffering from some form of anxiety, whether mild, moderate or severe. There were some quite concerning physical health problems, particularly pain, with 52% of people reporting experiencing some level of pain. That is important to mental health, because there are strong associations that have been shown between physical and mental health, and particularly pain.

Q3 **Chair:** To what extent are rurality and isolation part of what draws your attention to the mental health of farming in particular? We are trying to drill down into the differences between general mental health and that of the rural population.

Dr Wheeler: Part of it is about being rural, and I am sure that we will discuss lots of the issues to do with rural health provision and the challenges of being geographically isolated, which are very much a rural issue. There are also lots of farming-specific factors that are feeding into the issue within that population. I am sure we will talk about many of these today.

Q4 **Chair:** They will come out through general questions, yes. Sarah, can I bring you in now, please?

Sarah Hughes: Whilst prevalence is generally the same across rural communities as in urban environments, the reality is that it is worse for populations within those communities. As Rebecca has said, farmers have worse mental health. Young people have worse mental health in particular areas in relation to identity, for instance, or if they are from a marginalised community.

Whilst prevalence might be on an equal par, it is much more difficult for communities within communities. For those communities, it is much more difficult to access support. If we are thinking about 50% of our national population living in rural areas, one in four adults and one in six children are experiencing mental distress. More of those people will struggle in accessing support.

Q5 **Chair:** To what extent is mental health outcome-driven? Is it demographics, isolation, poor connectivity or a lack of access to services? Where do you see the particular issue?

Sarah Hughes: This is the difficulty in relation to mental health generally, in that it is a perfect storm of factors. What we know is that poverty is significant. When we have rural environments, pockets of poor communities are often hidden because we do not see them in the national measures for poverty, for instance. We have small pockets of Gypsy, Traveller and Roma communities, or children from marginalised communities or who have gender identity crises.

Within those communities, they have the most significant problems in terms of accessing support, recognising that they might need help, and generally getting that grassroots support too. It is a perfect storm. It is really hard to identify one area, but you might suggest, for instance, that we do not have the relevant planning at a local level to really understand the needs of our rural population. For instance, our long-term plan does not really refer to rural populations clearly enough to understand what the needs are exactly.

Chair: With the travelling population, I suppose it is about registering for services, let alone where they might be, and that is an issue too. I do not know if David or Rachel would like to make a comment.

Dr Rose: I am happy to. I would support what others have said. In our research, we spoke to 22 supporters of farming mental health. We heard from 93 of them via a survey, and what came out very prominently was

the complexity of the issues. Dr Jilly Hall, who worked as part of our team, has been helping farmers with their mental health for decades. She said that, 10 or 20 years ago, they were phoning helplines and talking about just one or two issues, but now there is a whole host of different stresses on farming mental health, and you cannot really solve the problem by just addressing one or two. You really need to solve all the different challenges at once.

Our research was particularly interested in the impact of Covid on farming mental health and the support that they got. The issue of isolation that we have talked about and will come on to featured prominently, because Covid-19, lockdowns and social distancing really increased that sense of isolation. Those places where farmers received even informal social support, in pubs, churches, agricultural shows and auction marts, were not available, so it really increased their sense of isolation, which was already there but was made worse by Covid. Clearly, complicated problems need complicated solutions, and there is a sense that you need to solve multiple issues to really make things better.

Chair: The farming community is interesting, because much of their business is part of their social life as well. When you take that away, you very much take away the social side of life as well. Rachel, as far as the Nuffield Trust is concerned, is there anything that you would like to add?

Rachel Hutchings: I echo what others have said in terms of the broader challenges, and emphasise that our work is more from the healthcare service perspective. A lot of the issues that we see generally in terms of accessing healthcare in rural areas would apply equally in the context of mental health—as has already been mentioned, things like travel and accessing particular services, in particular specialist services, and particular challenges for service providers in terms of operating within a rural context, which I imagine we will get to a bit later.

Q6 **Derek Thomas:** Rachel, I do not know if this would be part of your research, but do you think that we have a proper picture of the prevalence of mental health illnesses in rural areas? If so, what is driving that under-reporting?

Rachel Hutchings: The prevalence side of it might be a question for Sarah.

Sarah Hughes: As I said, it is really difficult to drill down on the prevalence, and there are a number of reasons for that. One is self-disclosure. One of our colleagues, Melanie Costas from Rural Mental Health Matters, has told us that if services are not seen, people do not think that they exist, so people generally do not disclose to their GPs and there is still a huge amount of stigma. There are still massive issues in terms of truly understanding pathways and access to help. In small communities, stigma is high. There is a fear of having your story exposed. All of those factors come into play.

The reality is that accessing help is incredibly difficult if you live in a rural or coastal area. The truth is that you are not going to see services on your doorstep. Whilst we see that there is a huge amount of resilience within these communities—and, indeed, some children report lower levels of loneliness than counterparts in urban areas—the reality is that it is about how people can access help and what is truly available to them.

The fact is that, if we are not measuring the needs of rural communities closely enough, we are not going to know. Assets have been stripped from local communities in a way that makes that measurement much more difficult. Community development, which might have carried out some of that close understanding of small communities, is not so readily available now.

Q7 **Derek Thomas:** The Centre for Mental Health has said that rural deprivation is an important factor in mental ill health but is not properly measured. You talked about measuring the prevalence of mental health. What is the problem with the current approach to measuring deprivation, and how can that be addressed, if that is a causal factor?

Sarah Hughes: This is a really important point, and thank you for asking me this question. We have lots of different measures that measure deprivation in local areas. In rural areas, we have far smaller pockets of villages and outposts where deprivation comes together. The national measures that we have just do not dig deeply enough.

As an example, we have a better mental health fund, which is an amazing and important bit of policy that we are very proud of. We are evaluating those 40 sites at the moment, but unfortunately they are in primarily urban areas, so we are not really seeing the rural deprivation at the same levels as you might do in London, for instance. You have to think about areas like Cambridge, which is where I live. I am a Londoner who decamped to Cambridgeshire. The wealth of Cambridge is not reflected in the Fens, which is the neighbouring area.

Q8 **Rosie Duffield:** My question has largely been covered, because it is asking Rebecca and David what factors they had identified. You said things like isolation, deprivation and all the things that we would expect to hear. You can expand on that if you want to, but how are those factors reflected in the support that is currently available?

Dr Wheeler: To expand on the factors that contribute, it is isolation and things that we have talked about. As others have said very eloquently, it is a whole host of factors. I hear again and again that it is not just one thing but the cumulative impact of lots of different stresses. That includes financial worries, pressures around the changing policy environment and the agricultural transition and the forthcoming loss of BPS. It is all those kinds of things. There are also social factors, which are partly about isolation but also—and I am talking specifically about farmers here—the workload and the long working hours, which mean that it is very difficult to take a break. In the survey, we found very strong associations

between poor wellbeing and not taking time off the farm or not taking a holiday. That is a really big issue, which is tied into the financial aspects as well. I could go on and I am sure we will mention others as well. There are cultural and physical health factors that feed into that.

In terms of how well that is reflected in support provision, it depends on which support you are talking about. The Farming Help charities do some really fantastic with the farming community. The people within those charities are very aware of the specific challenges faced by different subgroups within farming. As a broader healthcare provision, I do not think that that is necessarily reflected very well.

I am conscious that I am talking, so I might get cut off, but one of our key findings was that it is not just men in agriculture who suffer from poor mental health; there are also really concerning levels of anxiety and depression among women, which is not something that has been picked up before.

Rosie Duffield: We will come to that in the next question. David, do you have anything to add?

Dr Rose: In terms of the complexity factor, a farmer said to us that you cannot take any of these things in isolation. Another farmer said that, if your anxiety levels are up, you do not cope with anything lurking that you might normally cope with. There are a whole host of factors, including post-Brexit uncertainty, the fuel and energy crisis, and Covid-19, on top of all of those business and social factors that really stress farming mental health.

When it comes to support, we looked at the landscape of support and it is a very diverse range. You have primary healthcare, chaplains and mental health charities. You also have family friends, peer groups and people in rural communities who provide support. It is important that we do not focus just on formal primary healthcare support, but that we also look at more pastoral and social support that perhaps does not touch overtly on mental health, but is supporting the mental health of farmers and people in rural communities just from having a friendly face or a conversation.

Although you would perhaps automatically think that primary healthcare and mental health professionals are the place to go, we did hear one or two stories where perhaps people in those settings really did not understand farming. I am not suggesting that this is widespread, but we did have a farmer who said to us that they went to the GP with their worries and the GP just said, "Just stop farming". For the farmer, who has had that lifestyle for generations, that is not good advice. I am not suggesting that it is widespread, but it is about having that professionalism to understand mental health as well as farming, which is quite difficult to find. Many volunteers who support farmers have bits of both, but finding that in one source of support is challenging.

Q9 **Rosie Duffield:** It sounds like you would both back up what Sarah just

said, which was that assets have been stripped from rural communities as well. It is everything—the social things, the places to go and the things that people might have been able to access but now cannot. It is not necessarily just mental health support.

The second part of the question is mainly for Rebecca. What explains the poor mental wellbeing of people involved in livestock farming? Can you answer that? It is a bit specific.

Dr Wheeler: I can partly answer it, but before I do, it is important to say that we found that livestock farmers were more likely to be suffering from poor wellbeing, but it is an issue across the board. Even among the better wellbeing groups, it was still quite concerning. Livestock farmers have specific issues for a number of reasons.

It is sometimes quite a physical, manual job, which is tiring and might lead to physical health issues as well. It can be more challenging financially. In general, livestock farming is more reliant on the BPS than arable farming. There are lower profit margins, so the business pressures may be higher. We found that livestock farmers were particularly likely to be stressed by regulation, compliance and inspection. That is across the board, but it is something that they feel and struggle with particularly strongly.

We also found that they were a bit more likely to be lonely, which might be a factor of geography, but it might also be associated with high workloads and particularly finding it hard to get off the farm, because of finding someone to look after the livestock and all the rest of it. That is particularly challenging. There are then issues like animal disease, such as TB, which is extremely stressful in terms of the inspections associated with that, let alone finding TB in your herd.

In the research that we did specifically on loneliness, we heard people talking a lot about the public and Government opinion of agriculture and farmers, and a perception that farmers are not valued for what they do. That was found to be having a real impact on people. Part of it is about veganism and the threat that dietary shifts are potentially having. More generally, there is a feeling that farmers are not necessarily appreciated for what they do as key workers.

Q10 **Dr Hudson:** I have just a small supplementary. My colleague and friend, Kirsty, forgive me if my question is something that you are going to talk about. If that is the case, take Kirsty's question. Thank you for your exposé on your research, Rebecca and David. One of the areas where you can see that a lot of the line of questioning is talking about is farming and related industries, but we are very well aware as a Committee—we were just discussing this earlier—of the issues facing rural communities in general. Rebecca, you said that, in your research, you were asking farming households but that there were people answering your questions who were family of farmers. Is there anything on the incidence of rural mental health issues in those people who are not farmers or related to

agricultural industry? In a rural community, perhaps everyone is related in some way indirectly, but it is the non-farming side of things. Is there any research out there that you would be prepared to tell us about on that? Sarah, do you have anything on that? I guess it is a finding for our Committee that is a bit of an unknown. We have a line of questioning that talks about social deprivation and that side of things.

Dr Wheeler: I have a relatively brief comment, which I think you were about to go on to, in that there is an unknown there. We are beginning to build a picture within farming, but other rural professions like slaughterhouse workers, farriers or vets—maybe we will talk about that later—are a bit of an unknown.

Dr Hudson: The issues that people are facing, whether it is connectivity, transport issues, internet problems or a mobile phone signal that does not work, are ones that everyone in those communities is affected by. I guess that a take-home for us is that there is an unknown that we perhaps need to look at a bit closely.

Q11 **Kirsty Blackman:** I just have a brief comment on what Neil said. There are also things like food processing and whisky distilleries that are prevalent in rural areas, but again we do not have an idea of the effect on mental health.

The question that I was going to ask, Rebecca, was about the issues that you raised around people getting a break or not getting a break. Is there anybody who is managing to have time off? If there is, how are they managing to do this? Is this something that can be replicated?

Dr Wheeler: Yes, there are people who are doing it, and those people generally have higher wellbeing. It is a chicken-and-egg situation. Perhaps they are able to do that because they are in a better financial position. Part of it is also a mindset. Something that we found was that there is an expectation in farming that farmers work hard. That is what they do. It is part of their identity and it is necessary.

There are very real practical barriers that stop them taking time off from the farm, but there is also something about saying that it is okay to take a break. We have had stories of farmers boasting about being on their tractor 20 hours a day, six days a week, and wearing it as a badge of honour that they are doing all this work. That is not okay. We need to try to help change the conversation around that—to say that taking time off from the farm is a really positive thing to do; it is positive for wellbeing and for the business, but that is easier said than done.

Dr Rose: It probably depends on the nature of the farm business as well. There are different scales of business. If you are a one-man or one-woman band and you want to take some time off, you think, "Who do I leave this to?" If you are a bigger farm with a bigger team, they could perhaps cover when you go away. Smaller farms or farms struggling with poverty are worse off in many ways. They feel that they cannot take a break. I am sure that they could get others to cover, but there is that

perception that they cannot take time off. We see that too with farmers going to knowledge exchange events run by the AHDB and others. Those who do not have those bigger teams feel like they just cannot take any time off and go to these things, because there is no one left at home to do the farm work.

Q12 **Kirsty Blackman:** Do farmers ever get to go away on holiday? Is this something that ever really happens if they have smaller farms?

Dr Wheeler: Half of farmers say that they rarely take a holiday and a fifth never take a holiday, so no, but some do.

Q13 **Chair:** Just before we leave this, in terms of livestock farmers in particular—I have done a lot of livestock farming—if you are lambing sheep, you are very tired. The lambing may not be going very well and you might be losing lots of lambs, because there may be a disease that you did not know was there. To what extent does the research show those added pressures? Does that come through at all, and maybe on calving as well?

Dr Wheeler: It has come through somewhat in our qualitative research that there are particular pinch points. It is not something that we have quantitative data on, and I agree that that is something that could be looked at in terms of the seasonal aspect. One thing that I would say from our qualitative research is that there are seasonal timings, as well as pinch points in the life course as well. We find that there are particular times that people find particularly stressful, which might be having young children, the point at which they take over the farm or all sorts of things. They can be particularly stressful trigger points.

Barry Gardiner: I find that so far you have given us a lot of information, but I have not really felt that we have an explanation. One of the terms of reference of the inquiry is to find out the causes of the higher than average rate of suicide amongst those working in agriculture.

You said that farmers are perhaps macho and quite notorious for working hard. I represent an urban constituency. Let me tell you that somebody who works in an Amazon service centre is working blinking hard. They are often walking more than 10 miles a day and they are exhausted at the end of it. They do not get breaks.

You talked about insecurity. If you are a farmer, and particularly if you own the land, you have security. Compared with the gig worker in my constituency, you have a heck of a lot of security.

You talked about the difficulties of being able to access assistance for mental health in a small community, and you saw that community as being a problem, but isolation is felt by my constituents in a faceless city, where they do not know anybody and where they have no friends who they can go and talk to. I do not know whether you remember the scene from "Crocodile Dundee", where she is talking about a therapist and he says, "What is that? We just go and tell Wally at the bar."

What you have given me are a load of reasons that I can counter in my own constituency experience with similar issues, so you have not explained to me the underlying reason, which we are trying to find out about, for the causes of the higher than average rate of suicide amongst those working in agriculture.

Chair: Barry, I would like you to keep to the fact that we are inquiring into rural mental health. I understand your comparisons, but we need to come back to that.

Q14 **Barry Gardiner:** I want to isolate an explanation rather than information. In particular, what interests me is the way in which you have disaggregated in the report that you did, Rebecca, female agricultural workers as being more concerned in some cases about loss of subsidies and future trade deals, which was an interesting one to me. You talked about bad and unpredictable weather and the Covid pandemic as being specifically things that have affected women farmers. Again, I am looking for an explanation of how these things translate through and particularly why they affect women more. The one that you have said is critical for women is loss of subsidies and future trade deals, but why would that be something that affects women more?

The other thing that I would like to explore with you is that our briefing suggested that mental health problems in rural communities, as elsewhere, can be embedded by about the age of 24 and can be difficult to shift beyond that. Where is the focus on children's and adolescents' mental health? What is the research that you have done in this area? What light does that shed on the subsequent problems that people are having with their mental health?

I am playing devil's advocate here, because I want to get under the skin of this. I am not trying to counterpose city with rural.

Dr Wheeler: You make some very valid points and there is a lot to talk through, so I will try to pick out the main things that I wanted to say.

You are absolutely right that some of the characteristics of agriculture as an occupation are no different to other occupations. That is something where we would say that there are lessons to be learned from other sectors. We know that construction has, in the past, had quite high levels of suicide and poor mental as well as physical health. That is beginning to improve. I do not know a lot about that, but my point is that there are other sectors that we can learn from. I do not think that that research is there, so there is a lot more to be done to find out what other sectors are doing and what the parallels are, which, as you say, might help uncover the explanatory factors for agriculture.

On your point about rural communities, I certainly would not want it to come across that we are saying that rural communities are a bad thing. I have talked to lots of farmers who have talked very warmly about being in a rural community and about the farming community specifically, but I

will not go into that, because I do not think it is as important as some of the other points.

Barry Gardiner: But you did mention the stigma.

Chair: Hang on, Barry. Let us get the answers. It was a very long question and Sarah wants to come in as well, so could we just answer this question?

Dr Wheeler: I expect that we will come back to stigma. I just wanted to say something about women, who you specifically asked about, and their reasons for poor wellbeing. There are lots of things that feed into this and it is very difficult to give you an answer here and now. It is not that women were more concerned about loss of subsidies. It just so happened that, in the ranking of the factors that they were most stressed by, it was higher. That is not quite the same as saying they are more stressed than men by that, because there are differences in the sub-sample and all sorts.

One of the reasons why I think that might be a factor for them, though, is because often in traditional farming households it is the women who do the paperwork and deal with the finances, and who might be a little bit more conscious of the forthcoming changes and what those mean for the business. That is probably why that is in there.

Women are juggling lots of different roles: farming, non-farming, childcare. As much as women are taking on more and more roles within agriculture, it is still predominantly a male occupation, which has lots of implications for women in terms of their day-to-day lives: doing farm work, being involved in a diversified enterprise or perhaps off-farm work, and usually still looking after the children, leaving less room for other things and taking up a lot of mental headspace. Particularly if women are the primary farmer, they are working in a man's world, and I have heard stories of women finding that quite difficult. One person said that you have to be a damn good woman to be accepted in agriculture, because it is still a man's world.

Barry Gardiner: It is like being a woman in Parliament.

Dr Wheeler: Absolutely. It comes back to the point that they are not necessarily unique factors on their own, but it is the cumulation of all of these different things. I cannot explain why it is more or less than X other profession. I can explain what the factors are that feed into this issue in this population.

Sarah Hughes: I really do understand the desire to find out the nub of the difference and the nub of the cause, but, as I said, in mental health broadly, it is really difficult to identify one specific cause that is going to create this outcome, and so we have to, at some point, level our understanding of environments in that vein. These are complicated, perfect storm-type environments that create these outcomes.

Rebecca has been really clear about these factors that come together and coalescence around individuals and that make it much more difficult. As somebody who has lived in both an urban and a rural environment, you cannot underestimate the impact that pragmatic access to help means. If we think about the pandemic, accessing digital support in urban areas was much more easily achieved than in rural environments. From an access point of view, that creates delays and accelerates and amplifies distress. In terms of crisis, people are more likely to find themselves in a crisis that may include suicidal thoughts, because of all of those dynamics.

There are lots of mitigating factors for living in rural environments—green space, smaller communities and all of those sorts of things—but this is not an either/or scenario. To reiterate Rebecca's point, we are seeing that the specific needs of rural communities are not understood. We do not have enough research but we certainly understand that quite a lot of people living in rural environments are poorly served by mental health services. From that perspective, we need to address it.

Q15 **Barry Gardiner:** What about the children and adolescent mental health analysis?

Sarah Hughes: We undertook a report in 2018 that looked at the specific issues related to children and young people, where we were able to demonstrate that, for instance, fewer children and young people felt lonely than those in urban environments, so there are differences. Again, if we were to go into specific communities, if you are a trans boy or girl, you will have an exceptionally harder time in rural environments than you would in urban environments, so that level of nuance is where we need to get to and we are not there yet.

Q16 **Chair:** As far as women in farming are concerned, it is fascinating. From my own perspective, my mother not only milked the cows and looked after us but had to deal with my father, who was tensely complaining all the time that we were about to go broke. We sometimes do not realise the pressure that is put on women. Although it is a man's world, it is amazing how women in farming, even be they partners or wives, fight their corner very well. Do you think that the women come forward a bit more and say what problems they are facing, and that the men hold back?

Dr Wheeler: Thank you for asking that, because it raises a really interesting point. In general, we often think about women as more likely than men to open up on these kinds of issues. To a certain extent, that is true and perhaps they are more likely to do that before things get to a crisis point. However, it is an assumption that potentially needs challenging. I spoke to women about loneliness particularly but also mental health more broadly. They were very much talking about their husband, for example, and the issues that he was facing. I would then say, "That must be really tough for you. How is it for you?" and they would say, "Oh, I'm okay". There is certainly a thing there that women

are very much the caregiver. The survey showed that men are more likely than women to confide in their spouse. They are hearing all these problems and taking it on themselves to do that, without necessarily putting themselves first.

Q17 **Dr Hudson:** I very much take on board Barry's comments about trying to compare urban and rural. I represent a very rural constituency and I take on board Sarah's comment about it being very hard to find a trigger factor directly linked with mental health. One of the issues that is brought to me very much by my constituents is rural crime. In some of your research, Rebecca and David, you touch on that. There is crime in urban areas and crime in rural areas, and some of it is very similar. In rural areas, there are also different types of crimes such as theft of farm machinery or animals, poaching, trespass, fly-tipping and potentially animal cruelty. Is that something that is broadly a trigger factor, or is it too complicated and that is just another piece of the jigsaw?

Dr Rose: It is certainly a key driver of poor farming mental health. That came up prominently in our research. Rural crime was identified by many farmers as a real driver. During Covid, they brought up the idea of members of the public going out into the countryside because they could exercise, without quite understanding how to treat the environment. They mentioned a lot of sheep worrying, stress caused to livestock and even dogs killing livestock. It is not just about farm machinery and so on being stolen, but the day-to-day issues of public trespassing, accessing farmland and not treating it with respect, that cause unnecessary stress and worry to farmers.

Q18 **Robbie Moore:** This question is predominantly aimed at Rebecca and David, but the other two should feel free to come in. These issues have been covered but I am really keen to understand what the main barriers are that prevent members of the farming community from seeking help for their mental health.

Dr Rose: There are several. Again, our research looked particularly at Covid. What was clear was that Covid simply exacerbated the barriers that were already there. There is a cultural and social barrier. We have spoken about the idea of stigma and the sense that having to seek support for mental health may be seen as a weakness. There is the idea that, if you have close-knit rural communities and someone finds out that you are getting support for mental health, it might be seen as something quite embarrassing, which of course it is not. Then there are the infrastructure issues such as poor broadband and poor public transport, which make it harder to access these services. That is in terms of geography and infrastructure.

There is a certain amount of a lack of awareness about where best to seek support and whether it should be mental health charities, of which there are many, or whether it should be primary healthcare or chaplains. There are lots of places where farmers can go, but it is not necessarily clear for each individual where best to go. There is a clear sense that

different types of farmers and different individuals will benefit from different forms of support, and there is not that awareness about where best to go.

The stigma, the geographic isolation and the infrastructure issues are probably the most prominent ones. In addition, farmers are very busy and have a lack of time, which can prevent them from seeking help.

Q19 **Robbie Moore:** What I am also keen to explore, which has not been touched on so far, is the fact that many farms operate in an isolated environment and are also family-based businesses, which have grandparents, mum and dad, and son and daughter all involved within a very confined, isolated working environment. Maybe there will be two houses on that farm, and then the different challenges that exist between the different generations.

That, to me, is almost a uniqueness, particularly combined with the isolated environment in which those family members are working. Have you found, through research or engagement with those types of scenarios, that relationships either exacerbate mental health issues or some of the challenges associated with those shared experiences?

Dr Rose: I can be very brief on the Covid aspect. Farming families who spoke to us spoke about families being together more during Covid, because those who worked or went to school off the farm were confined on the farm for long periods of time. For some farming families, it was a great source of comfort and quite nice to have the family there.

For many, when they could not get off the farm and were having to spend a lot of time together, there was a discussion about family relationship breakdowns, stresses, different ideas between the generations and conflict. There was that sense that the longer you spent together, having to juggle home schooling and childcare with everything else, the fact that you lived and worked in the same place often brought those personal conflicts to a head in a way that you perhaps do not get in other settings.

Q20 **Robbie Moore:** Just following on from that—I am saying this partly from experience, having been involved in the ag sector prior to entering here—did your research find any pressure scenarios in relationships between husband and wife, where both individuals are specifically involved in the business and pressure points are being added to mental wellbeing within that relationship structure of a family set-up?

Dr Wheeler: The short answer is yes. Where there are good family relationships, they are great, and intergenerational living is fine. You can get childcare from your grandparents, so there are benefits; there is the support. Where they are not so good, it really does exacerbate the issue. It is something that requires more research. To link in with Barry's point about children, this is not something that we have looked at. We have looked predominantly at adult mental health, but we know that these issues can start very young. Tensions within the family, from an

intergenerational aspect and between a husband and wife falling out within the terms of the business, are key to that.

There are so many issues around this. You are living and working with your family, which is going to be difficult for anyone, whether or not they are in farming. You have capital tied up in shared assets. You might have succession issues about who is going to take on the farm, which is extremely stressful. Not all families have the open conversations that they should around that. There is also pressure on young people to take on the farm, whether or not they want to, and all that that brings with it.

There can be positive aspects. I spoke to people who said that growing up in farming has made them really resilient and given them a great work ethic. I have spoken to so many young farmers who I have been in awe of, because they seem so mature for their age. I have loads of respect for what they are doing at such a young age, but where it goes wrong, it can really go wrong, and there are some really unhealthy relationships within that setting that can be quite difficult to get at, for all of those and other reasons.

Q21 **Kirsty Blackman:** In Aberdeen and Aberdeenshire, we call people who live in the country teuchters and people who live in the town toonsers. I spent a third of my life living in the country, but I would firmly be called a toonser. From the point of view of toonsers thinking about rural areas, there is a view that they are less accepting and that there is more stigma and more issues. Is it the case that there is more stigma about mental health in rural communities, or is that just a view that we have in urban areas?

I have a slightly different question following on from what Sarah said, who mentioned the issues that people might face if they do not fit into a cis, straight, white box. Is it the case that that is more of a problem for people living in rural communities than it is for people living in urban communities?

Sarah Hughes: Yes, without a doubt. We find around the country that people who have any difference from the white, cis, hetero perspective do experience higher levels of stigma and are more likely to take their own lives. There are lots of assumptions that we can make, which have been fairly well tested over the years, around the reality of stigma in rural communities. It is fair to say that it is relevant to different pockets. For instance, I live in a town that is very close to very rural areas. There would be slight deviations between us and the very rural areas. There are huge differences in the acceptance of differences between rural areas and London or really big cities.

We know that, for children and young people, there is a particular problem around developing identity and being able to recognise and see other people who are similar to them. We know that, for people who come from racialised communities, it is particularly difficult if you are the only brown or black child in a school, which is the case for some people

where I live, for instance. Those are particular issues that marginalised groups experience in rural areas, and they are absolutely raising the game in the stigma stakes.

Q22 **Kirsty Blackman:** Is there more stigma around talking about mental health and those things that we know help in rural communities, or is that just a view that we may have from the outside that is not necessarily tested and proven?

Dr Rose: From my perspective, it is difficult to answer the question. I am not aware of any research that can prove either way what you are saying. There is a perception that perhaps there are more traditional rural areas that struggle to open up about these things, but I cannot give you an answer to that.

Dr Wheeler: I fully agree. It is difficult to make that comparison. To a certain extent, it is not particularly helpful to make that comparison anyway, because we are looking at the rural area and we know that it is an issue in the rural area. To the extent that it is an issue in an urban area, I suspect that there is a difference, but I cannot say with any certainty that there is.

Within the farming community, in terms of stigma and awareness of mental health, there are signs that it is beginning to change from the generational aspect. Younger people within the farming community are a little bit better at opening up and talking about it, and I know that young farmers' clubs have done stuff around mental health as well, which is brilliant.

Q23 **Barry Gardiner:** I wanted to ask about sex, which has been remarkably absent from our discussion, with the exception of LGBTQ. I do not want to get into the tropes of farmers' dances and finding a partner, but traditionally, if you are a farmer, you need to find a partner who wants to marry into the farm, which can also be extremely difficult. What research have you done around sexual frustration or the inability to source a partner, maybe because of a lack of time or opportunity in your community? It seems to me that we need to dig deeper here than we are, and I just do not feel that we are getting it at the moment.

Chair: Dare I say, Barry, that I think young farmers' clubs play quite a good role in that, but we will not go into all those details.

Barry Gardiner: Particularly livestock farmers like yourself, Neil, I am sure.

Chair: But seriously, it is a very good point.

Dr Wheeler: The short answer is that we have not looked at that specifically. It is a good question. What I can say is that it has come up in some of our research. For example, in the project that we did on loneliness, which was qualitative work with farmers, I spoke to one youngish chap who had very much struggled with that side of things and said that he found it difficult to talk to girls right from the start. He would

have a girlfriend but there always had to be a girl who was linked to the farm in some way, because of his working hours. Ultimately, he had several failed relationships, because he did not devote the time that he knew he should to that relationship, but he said, "My passion is farming. I cannot stop that", even though he could see that that was going wrong. Relationships can be very difficult in farming, for lots of different reasons, but beyond that I am not sure that I can add much to your question.

Chair: We will probably park that one there. It was a very brave question from Barry. Sarah did you want to comment? You were looking intently there at the screen.

Sarah Hughes: It is really interesting. One of the things that I am hearing really strongly from the Committee is a real desire to understand, at a deep level, what the specific differences are. It might be helpful to reframe that and to hold in mind that what we are trying to offer the Committee is a real sense of understanding the broad issues that rural communities experience. They are not hugely different from urban environments, but the distinct difference is about how we, as a decision-making body, respond to those needs.

We know that access to services and all those tangible things like pragmatic access and diagnosis are much more difficult. There is something about the research not having the level of nuance that the Committee would really desire, and that may be something that you could influence research funders about, because there are areas of interest. There are other mechanisms that we could focus on in terms of the solutions to some of these problems that really attend to rural experiences.

Q24 **Chair:** Part of the question is about how we can remove some of those barriers to seeking support for mental health. Very simply, how do we do that?

Sarah Hughes: I have a list that I made earlier and could read from. I will just go through some of them. First and foremost, we have national planning systems like the long-term plan and others that really try to understand the needs of communities. We need to make sure that rural communities are in there and that we really think about workforce needs for rural communities, rather than just hoping for the best and that national plans will apply.

We need to co-produce wellbeing solutions with local communities. My brother, who works for Cambridgeshire, Peterborough and South Lincolnshire Mind, oversees a small grant-making programme that offers local communities opportunities to fund their own wellbeing and mental health support. We need to think about how we use the integrated care systems that are coming up, which will enable us to drill down at the level the Committee wants. I could go on, but I am sure that my colleagues have ideas too.

Q25 **Chair:** There were some very good points there, thank you very much. David, you wanted to come in.

Dr Rose: Just very briefly, Mr Gardiner brought up the LGBTQ community. We did a literature review as part of our research, and there were a few papers, mainly from America—I can send them to the Committee—that looked at the challenges of a farmer within a traditional community facing issues of sexuality and being able to come out and share that with people who they thought might not necessarily be as accommodating as perhaps other sectors. There has definitely been some research that looks at those issues, which I can send to the Committee, but that is another key driver that means that some farmers struggle.

Chair: It is a generational thing.

Rachel Hutchings: Not on that specific point but more generally, I would echo what others have said in terms of the level of detailed research and unpicking some of these things being not quite there yet. What is also important to recognise—and we come at this, as I said, more from a healthcare service perspective—is that a lot of the issues that we are identifying are systemic challenges across the health service as a whole.

Chair: We are going to come on to this one, so I will bring Neil in and I suggest you come in first on mental health services.

Q26 **Dr Hudson:** I was going to direct my first question to Rachel. Sarah, you mentioned that part of the issue now is talking about the solutions and how services can be delivered, so that is what I want to focus on now first with Rachel. Rachel, could you give the Committee and the public a general perspective on how mental health services are structured and delivered in rural areas?

Rachel Hutchings: Yes, picking up on the points that have been made already, it is important to note this is a really complex landscape. There are lots of different actors and bodies involved. We have talked a bit about formal healthcare services and I know David has mentioned the informal support as well. In terms of exactly what that looks like in different areas it is going to be quite variable in terms of what actually exists within particular localities. As a general rule, often the first port of call might be GP primary care and then potentially getting referred to another service for more specialist support, depending on what the particular needs of that person are.

In terms of the exact make-up of what those services look like, it is going to be hugely variable across the country, and also the informal provision.

Q27 **Dr Hudson:** That is very helpful. I will come on to the second part of my question. Sarah, I will come to you in a second on this. On the challenges facing rural communities in terms of delivering that mental healthcare, you said the first port of call will often be the GP. In that sense, we know the issues of recruitment and retention of GPs in rural practices. Do you

have any perspective on the challenges in that sector?

Rachel Hutchings: Yes, absolutely. Our work has looked more broadly across rural services, so mental health but other aspects of healthcare as well. We have tried to unpick some of the particular challenges the organisations might face in rural areas. Workforce, as I mentioned, is a key challenge across the whole of the NHS, but there are particular issues in rural areas, not just with primary care but with lots of other roles as well. There are particular issues around recruitment but also retention; that could be to do with there being a smaller pool of people to recruit from. We have found that NHS organisations in rural areas can often be more reliant on agency or locum staff to try to fill some of those workforce gaps.

Workforce is a particular challenge from a recruitment and retention point of view but also when looking earlier on in terms of training and education. I know there has been a lot of focus on trying to support greater focus on training and education opportunities in rural areas. We know that is not necessarily widespread across all professions, so we did some work on mental health nursing, for example, which is obviously a key profession when talking about mental health services. Looking across the country, we found there is wide variation in terms of available opportunities for people to study and enrol on those courses. In terms of workforce, it is looking across the board at both opportunities for training but also recruitment and retention.

Again, we talked about those systemic issues around infrastructure as well, available services and access to services. We find that more generally, not just within mental health, there are challenges around proximity to services, proximity to specialist services in particular. We have also touched on technology, which has obviously been a huge part of the pandemic response as well. One of the particular challenges in rural areas is not just for people who want to access those services but for healthcare service organisations themselves, in terms of actually having the capability to use the opportunities and to use technology in ways that could offer opportunities for increasing access.

There are also some nuances around funding and how resources are allocated, but you might come on to that separately in a minute.

Q28 **Dr Hudson:** Rachel, you have done a great job there in terms of the flow of questions to go into the third part of my question as well, which is about the extent to which the mental health services provided in rural areas are actually designed with the specific needs of those communities in mind. You have touched on training and education for mental health training for nurses and potentially community practitioners.

Is there a role for really designing it for the rural areas so that community practitioners will have some of the expertise to be able to signpost people? Will there be more mental health first aid training, potentially having first aiders in schools and other businesses in

communities? Is that bespoke training for people to be on the frontline in these geographically disparate areas something that we as a Committee should be looking at?

Rachel Hutchings: I would definitely emphasise the significance of workforce in thinking about how people in rural areas are actually supported. Sarah has alluded to this already when talking about the overall ambitions and plans for improving mental health services more generally and actually how important workforce is within that. She also touched on the opportunity for integrated care systems to look more closely at the needs of local communities, to try to unpick that a bit.

This perhaps relates to the earlier conversation about trying to unpick what we actually know about mental health outcomes in rural areas. One of the things to perhaps touch on is that it is actually quite challenging to do that with the available information and data that we have, from an NHS perspective. We are often looking at broad areas that might have pockets of places that are rural within them but also urban areas as well. Trying to unpick the information that we have about what is needed in local areas is an area that needs greater attention as well.

Dr Hudson: Thank you; that is really helpful. Sarah, can I pivot that line of questioning to you? Can I have general comments from you on the commissioning and delivery of mental health services in rural areas?

Sarah Hughes: Yes. My colleague, Rachel, has done such a great job of talking about NHS services, so perhaps I can focus on social care in the third sector, which is where my expertise primarily lies. My last job was as chief exec of CPSL Mind, and we covered a huge area. I will give you a tangible example of why it is difficult in rural areas to deliver service at the same level as in urban areas. If you are delivering home and community support—support to somebody in their homes—that will be generally funded by your local authority. We know local authority contracts for this type of support are really stretched and often hard to cost well.

If we are delivering the service from Cambridge, for instance, but we have a client in Wisbech, we cannot get the staff to deliver the service in Wisbech because of local issues around workforce. We have to send a member of staff from Cambridge to Wisbech for maybe less than an hour's visit with a client. That entire service might take half a day or two thirds of a day, if that member of staff does not have their own transport. The local authority funding does not fund all of that process.

The struggle for local authority funding and third-sector organisations is this: they are often only paid for half of the job, because the whole job in rural areas probably costs at least double what it might do in London, where transport is more feasible. If you are talking about travelling from where I live to Wisbech, that is a journey and a half. Then when you are taking on top of that the additional costs related to that person in post, delivering services during the pandemic, it is exceptionally high, and

there are issues around managing sickness and all of those operational demands.

You cannot underestimate the impact that this is having on the third sector. We know from our charity colleagues, who are providing public services, that they are often holding people who have a high level of need, who would usually be seen by secondary care but are not. They are being held by grassroots communities. There is a whole complex system of funding that creates the conditions for that.

Q29 **Julian Sturdy:** This leads right on to the funding issues. Sarah, you have touched on the travel issues, the time and the cost of that. We all know that delivering a lot of services in rural areas is much harder and much more costly on the back of that. It is not just mental health services; a lot of healthcare services are much more costly and time-consuming to deliver in these rural communities. My question is about whether the funding for mental health service in rural areas reflects those additional delivery costs that you and the service providers face.

Sarah Hughes: The answer is no.

Julian Sturdy: It is a simple answer.

Sarah Hughes: It is a simple answer, yes. I could go into detail. I do have optimism that the integrated care systems will be able to tackle this because of shared and pooled budgets and much closer collaborative working. As it stands at the moment, the social care baseline for mental health services, as an example, is far too low. We know that when you are costing for remote access to digital care, there are often the up-front costs that are not built in. There are so many hidden costs that we have not been able to service in a way that has made a difference.

Chair: It might be quite useful, Sarah, to let us have some of your detailed ideas in writing as well.

Julian Sturdy: Yes, I would agree with that. I do not know whether anyone else from the panel would like to comment on that.

Rachel Hutchings: I was just going to give a bit more of a flavour on the NHS side in terms of how that is accounted for, if that would be helpful. In terms of NHS resource allocation, it is an extremely complex way that funding is allocated to clinical commissioning groups, based on a combination of factors. One of these is need, which is predominantly driven by the age of the population but also other factors. There is some adjustment for organisations that are termed unavoidably small due to the population size that they serve—under 200,000 people; proximity to the second closest hospital—but it is only for organisations that have an A&E. I believe it is only seven organisations that fall within this category and get that adjustment. There is a longer-standing adjustment for ambulance organisations to account for the additional costs of rurality.

Some analysis that my colleagues did found that that adjustment for organisations that are deemed unavoidably small is quite small relative to the adjustments for other factors around age and all of the other factors that are involved, which, alongside the historical spend and how to balance out the finances, means that it has had the effect of actually focusing funding more on urban areas rather than rural areas. Whether it sufficiently accounts for the additional costs that come with providing care in rural areas is still up for discussion. That is more generally, rather than mental health specifically.

Q30 **Julian Sturdy:** You have mentioned that there is some calculation within the NHS funding formula for rurality. I am led to believe that is quite small though, is it not?

Rachel Hutchings: Yes. The analysis that I was referring to found that that adjustment relative to the adjustment for other factors is quite small.

Q31 **Julian Sturdy:** Would you say that does need to change going forward?

Rachel Hutchings: It is an extremely complicated question and the funding formula itself is very complex. We need to try to interrogate whether the additional costs that rural services might face, as Sarah has articulated, are effectively accounted for. Moving to integrated care systems as well, trying to unpick within those larger organisations how that is reflected, is probably an area of focus.

Q32 **Julian Sturdy:** Just to finish on the final point of the question, do you feel the additional Government funding for mental health services put rural clinical commissioning groups in health trusts on a more sustainable financial footing, or do you think that there is still much more work to be done there?

Rachel Hutchings: I am not sure I can comment specifically on how that additional funding was necessarily specifically allocated, in terms of whether it was outside the normal formula or whether it was via that. We have found in the past that, where there is additional funding that has been announced that is discretionary that organisations have to bid for, rural organisations have missed out. Exactly how that has been allocated, I am not fully sure. I would have to follow up on that.

Q33 **Julian Sturdy:** Sorry to interrupt, but that is quite a key point, is it not? I know we are probably going wider than the scope, but it is all about rural services as well. If rural groups are missing out on those potential pots of funding, is that because of the bid process or maybe because they are not reaching certain parameters that you have to reach to access that funding? Do you feel that there is an underlying issue there, almost going back to how mental health services in rural communities are funded and are able to access additional costs of funding compared to more urban areas?

Rachel Hutchings: I am not sure on precisely the exact barriers that were present in that. I can definitely follow up with a colleague who was involved in that analysis. That was looking historically at some previous funding that was announced and found that rural areas have missed out, but I would have to get back to you on the exact reasons for that.

Julian Sturdy: That could be quite important to the inquiry, if they are missing out on potential pots of money. Does anyone else want to comment on that?

Sarah Hughes: I just want to add an example of where rural areas miss out. I mentioned the better mental health fund. There are 40 pilot areas that had additional investment, all of which are primarily urban environments. That was because the formula for testing for deprivation, as I said earlier, was very broad. The nuance for rural areas was largely missed. Although that fund is excellent and we are very pleased to have it, yes, it did miss out rural areas because of the way the formula operated.

Q34 **Julian Sturdy:** Do you feel that rural deprivation is not properly covered within the funding formula?

Sarah Hughes: Yes, it is not well measured.

Q35 **Chair:** Sarah and Rachel, there is rural and there is rural. What I mean by that is you can be in a rural area but you are not very far from the centre of excellence, the cities or wherever. Take Devon: you can be in Exeter or not far from Exeter and it is still quite rural, but if you go up to Great Torrington and Holsworthy, close to the north Cornwall borders, you are in no man's land—miles from the service. Does the funding formula recognise the sheer miles that you might have to travel? It probably does not.

Rachel Hutchings: In terms of healthcare provision and the definition of rurality that informs that, it is not necessarily consistent. The example I gave with clinical commissioning groups talks about being unavoidably small due to remoteness. There is some adjustment for rurality with the primary care allocations, which relate to distance from practice and also population density.

This is a really important point. It is reflected in the way that healthcare services actually work for their populations as well, in terms of the nuanced needs within different areas. Although there are commonalities that rural areas face, there are also a lot of diverse issues as well. Sarah mentioned coastal areas earlier. That is one example. That is really important to unpick—recognising the diversity and nuance within rural areas. It probably links back to the wider conversation earlier about the focus on farming, and focusing on other professions and other people living in those areas.

Q36 **Derek Thomas:** David, my understanding is that you did some research that said that the Government play less of a role co-ordinating rural

mental health support than some other Governments, such as in New Zealand and the Republic of Ireland. What are those Governments doing that you would like to see replicated here?

Dr Rose: On the specific example of Ireland and New Zealand, I will write to the Committee afterwards, because that was prompted by a special issue of an academic journal we are curating. We have nine papers from around the world. Three are from the Republic of Ireland and one is from New Zealand. When we had a chat in a workshop about it, those Irish and New Zealand authors looked at the very messy landscape of support we have and said, "Why do you do it like that?"

There is one good example I can give you, which is from within the UK, comparing the landscape of support for farming mental health in Northern Ireland with England. In Northern Ireland, there is an organisation called Rural Support, which has a longer track record and is seen as the organisation that is the go-to place to support farming mental health. Because of that, there is a close relationship between that organisation and all the different stakeholders that you need to bring to bear to support farmers. That includes Government. DAERA and policy makers work very closely with Rural Support. We recently held a workshop where we brought policy makers and organisations together, which the Chair spoke at. You could see the close relationship between people from Rural Support Northern Ireland, the policy makers and a GP we had from Northern Ireland. It was a much more connected landscape.

If you compare that to England, it is a rather messier landscape of support. You have broadly the same type of people—agricultural, pastoral, social and spiritual support—but it seems much less co-ordinated. Of course, there are geographical differences, but the role of DEFRA, for example, in that landscape of support is much less well articulated. I looked at its response to this inquiry. It is a relatively short response. There is a real sense from reading between the lines that this could be an issue that falls between DEFRA, the Department of Health and Social Care, and the Health and Safety Executive. DEFRA was not quite clear on what its role was in this landscape of support.

The English landscape of support for farming mental health is clearly much less connected than the Northern Irish example. Although in the workshop we heard many great examples of organisations in England working together, we also heard examples of conflict between larger and smaller organisations, either for funding or concern that an organisation changed its modus operandi, started to do something different, overlapped with or went on to the ground of another organisation, and conflict occurred. The Northern Irish is a good example. There are geographical differences, but it is much more joined up than it is in England. It is for DEFRA to at least consider their role and the role of wider Government in supporting this landscape.

Q37 **Derek Thomas:** You will be familiar that, in terms of mental and physical healthcare, in England we divide it into STP areas. Cornwall and the Isles

of Scilly would be one area. Would your recommendation be that you actually match support for farmers' wellbeing with those geographical areas as well? Obviously, in the whole of England, integration and joined-up thinking is not really our thing.

Dr Rose: Yes, it is a good question. There is more thought that is needed about it. There are players in the landscape that have a national focus. There are players that have a regional focus. Some regions of England are better covered by support services than other regions of England. There needs to be some thought about who does what and where. That needs to be beyond just DEFRA.

Q38 **Derek Thomas:** Rebecca, you might want to come in; David, do feel free to as well. The Government announced this £41 million future farming resilience fund to fund organisations during the agricultural transition through Brexit to the new way of working. How would you want to see this money best used to support farmers and mental health colleagues during the transition?

Dr Wheeler: The support that is being offered under future farming generally, and also particularly the future farming resilience fund, which is funding free advice, is valuable. It is a step in the right direction, because it does address that link between the business side of things, mental health and the stresses there.

I am slightly involved in an evaluation of the interim phase of the future farming resilience fund at the moment, so I do not want to pre-empt too many of the findings of that. What I can say is that it probably needs improving for the next round, in terms of consistency of advice being provided by different providers. Some farmers are finding it really useful, going along to workshops, getting one-to-one advice. Others are not having the same amount or quality of advice.

There are also issues around the extent to which that will reach enough farmers, whether it will reach the farmers that really need it and whether it will continue long enough to support farmers throughout the whole transition and beyond. Those are perhaps more unknowns.

More generally, every bit of advice or support that can be offered to farmers is great, but it needs to be integrated and needs to be thinking about improving business resilience generally.

There is also scope for including mental health more specifically, particularly within the future farming resilience fund programme, where it is within the remit of the programme but at the moment providers are not necessarily touching on it that much. That is a bit of a missed opportunity, because this could be a really good opportunity to have the conversation, start breaking down those barriers about stigma, talking about it and signposting funds to the right places for support.

Q39 **Derek Thomas:** That really feeds into the Chair's point that, if you live close to Exeter, you could probably actually access greater advice on

stuff. I represent west Cornwall and the Isles of Scilly; you probably cannot get much more rural than the Isles of Scilly. How do you get a fund like that to really get to the hard to reach? It must be a massive challenge.

Dr Rose: I would agree with the point that is made. It needs to be more than just business advice. It needs to be pastoral advice and other forms of advice. We have 42% of farmers who do not make a profit above and beyond BPS. I just looked at the farmer opinion tracker from October 2020 this morning, which had the latest responses to DEFRA from 1,200 farmers. Some 36% of farmers do not understand DEFRA's vision for the future, 52% are not confident in their relationship with DEFRA and 47% are not positive about their future.

If there are 47% who are not positive, we have to really make sure that this support that is being offered through the resilience fund reaches that 47%. It is no good if those 19 organisations that have received the money talk to the 53% or slightly less than that that are more positive. It has to reach the harder to reach.

Dr Ruth Little from Sheffield, who has spoken to the ELM inquiry, has done some work. We have done some work on the harder to reach. It is about identifying those skilled intermediaries, those trusted advisers—those trusted people and facilitators in rural communities—to work through to give the funding. In the initial phase, £9 million has been given to 19 organisations. It is really important to broaden the scope of the type of organisation, and even the type of individual, that can access money to provide support to farmers. It needs to go beyond business advice to perhaps some of those mental health charities, chaplains and others who can really prepare farmers for very uncertain and challenging decisions.

Derek Thomas: We have some good examples of where that can happen in Cornwall. I do not know if they will take part in the inquiry or not.

Q40 **Chair:** Rebecca, you said you are doing some direct research into this particular fund, are you not? If you are in the fairly near future finalising that, please let us have it, because it can very much be important evidence for us.

Dr Wheeler: I will do. It is being led by Ipsos MORI; we are partnering them.

Chair: Thank you. It would be very interesting if we could make this fund work better than it is at the moment and perhaps get DEFRA a little more connected, dare I say it, than they are at the moment. That would work well.

Q41 **Robbie Moore:** Rachel, how well do you feel that NHS mental health services support the farming community during shock events—things like foot and mouth, the bird flu crisis, flooding and the recent Storm Arwen

event that hit predominantly the north-east?

Rachel Hutchings: I am sorry; I personally cannot answer specific questions on those particular challenges in the farming community.

Q42 **Robbie Moore:** Rebecca, can you answer?

Dr Wheeler: I am not sure I can say that much specifically about the NHS mental health support following shocks like that, just because I do not know enough about it. I know that the financial support that is sometimes offered after things like flooding is gratefully received. David might have more to say on that specific question.

What I would say in relation to the issue about support after shocks is that, although, yes, you do need more support at certain times, it goes back to ensuring resilience across the board so that these shocks do not have such an impact. Most of the time, that particular incident is not the sole cause of the mental health issue. That will just be the straw that breaks the camel's back. It could be that; it could be something else.

Yes, flooding might affect a particular area, but actually often there are farms every single days facing shocks, in the form of TB, deaths or whatever it might be. Yes, targeted support after events is useful, but that does not really get at the root of the problem.

Q43 **Robbie Moore:** Do you think that there is enough capacity and provision within the NHS services to be able to provide the mental health and mental wellbeing support to the rural economy and farmers when there are big national events such as foot and mouth, which hit the rural economy exceptionally hard?

Dr Wheeler: My main point is not so much about capacity in terms of resources, which I do not know that much about. What I would say is that there is a lack of understanding within healthcare professionals about the specificities of farming. David alluded to that earlier, with the GP who said, "Well, just give up farming". That is the key thing. We should be making sure that GPs in particular, but all healthcare providers in rural areas, have enough understanding to be able to deal with these kind of issues sensitively and signpost if necessary. It is all very well making sure there is great healthcare provision, but if farmers are not going to go to them because they do not think their GPs are going to understand them, then you are not getting anywhere.

Rachel Hutchings: I wanted to come in quickly on the point about the Covid-19 pandemic—not so much on the specific support provided to people in the farming community as a result of that, but just more widely thinking about the impact that has had on the provision of mental health services more generally. Just thinking about the resilience of the services as well, it is only today we have seen that the number of mental health referrals is at the highest it has ever been. There was a lot of pressure on services prior to that. It is just thinking about the impact of the pandemic

on the NHS's ability to provide services more generally, as well as the specific support.

Dr Rose: Our research particularly looked at Covid-19, which is in itself fairly unique, but certain aspects of isolation we have seen before, although slightly differently with foot and mouth and other shock events. Although it is important that more support is given in the short term, we should be mindful that the impact of some of these things can take a long time to become apparent. We still have communities who struggle with their mental health because of foot and mouth, which happened 20 years ago.

What Covid illustrated with the landscape of support for farming mental health was that it was not ready for the scale of the shock of Covid. There were people in farming communities who were failed because of how existing services were planned. There is a quote that stands out from one mental health charity that said that it had to pivot towards doing things online, with Zoom meetings. One said to me, "There is a reasonable percentage of farmers who are not IT-literate, so we could not reach those". They are not IT-literate because of issues of poor rural connectivity or poor digital skills, or because they do not have the money to access IT equipment. There was a certain part of the farming community who could not be reached as easily.

S4C in Wales did a documentary about the state of rural mental health and the impact of Covid. There was a very tragic, heartbreaking story of a young man who committed suicide as a result of mental health challenges. He reached out for support. He had reached out and he got an online Zoom appointment from a nurse, who had that appointment and was going to signpost him on, but it took several weeks for that appointment to happen in the first place. After that appointment, the family felt that he did not really get the support he needed. Very sadly, the support that perhaps could have come later on came too late.

There were examples of farmers and people in rural communities who were failed by how things are currently arranged. We need to learn lessons so that we can reach all of those who need support in the future.

Sarah Hughes: I just want to make a point about flooding and economic and socioeconomic shocks. We know that flooding can happen in urban environments as well, but I am just thinking about rural environments for a minute. We know that people who experience flooding are between four and 8.7 times more likely to experience mental health challenges like anxiety and depression, and 30.4% of people who have experienced extreme flooding and weather conditions will have prevalence across their lifetime of post-traumatic stress disorder, as opposed to 7.8% of people who have not experienced flooding.

We have some information that could enable local areas that are in floodplains to perhaps think, "We potentially will have more people who will experience post-traumatic stress disorder in this environment, so we can adjust the services", and so on. We also know that this triple threat

of Covid, Brexit and now the war in Ukraine certainly poses a very specific challenge to farmers. Again, there are things that we know about significant global events that have particular impacts on particular communities. We could draw that evidence together.

Q44 **Kirsty Blackman:** Just on what Sarah said there, there is a tendency from politicians to catastrophise; I do not know if you have noticed. I am just wondering if there is any slack left in the system. Is there any resilience left? You were talking earlier, Rebecca, about the numerous things piling on and then there just being something that would normally not be that big a trigger point being something that destroys everything. Given that we have had Brexit, Covid and changes to the new way that the farms are funded and all of that, is there any resilience left in the system? Are we looking at there being an issue unless we act now, or is everything okay?

Dr Wheeler: It is very variable from farm to farm, to be honest, and from sector to sector. It is quite difficult to answer that. Yes, the war in Ukraine is going to have a significant impact on people who buy fertilisers. For others, it will not be such an issue. They might be benefiting from increased cost for wheat. It is very variable. It is going to have a very variable effect.

There is resilience in farming generally. We must remember that, although I have emphasised the concerning levels of poor mental health, it is still a minority. The majority are doing okay and might even have high wellbeing and their businesses are going to be okay. Yes, it is more likely to be smaller and medium farms; it is more likely to be livestock farms who are going to be struggling in the face of all of these pressures. The short answer is, yes, there is resilience in some farms and not in others.

Q45 **Dr Hudson:** I just wanted to get now on to the subject of suicide incidence and prevention. I declare an interest as a veterinary surgeon. Our profession sadly is over-represented in terms of mental health issues but also, sadly, with the incidence of suicide. I also declare an interest that I was, in my previous life before coming in here, involved in some research in that area. I will come to you first, Rebecca. Are the drivers of higher than average suicide rates amongst those folk who are perhaps involved in the agriculture-related professions the same as we have discussed earlier today, or might additional factors be involved?

Dr Wheeler: Yes, of course all of the things that we have been talking about feed into it. Research has shown, as I am sure you are personally aware, that knowing someone who has tried to kill themselves is a factor contributing to you being more likely to go through with it. Since there is a high prevalence of suicide within agriculture, that is obviously an issue.

It is also about access to means and knowing how to use them, so easy access to firearms and poisons of various sorts—that is true for both vets

and farmers. The additional factors just add on to all those other stresses that we have talked about.

Dr Hudson: The next part of the question was looking at veterinary surgeons, and you have touched on that. Does anyone else have anything to add?

Dr Rose: We did not specifically look at veterinary surgeons or advisers in our project. We mainly focused on farming families. I would just echo what Dr Wheeler said about some of the similar issues being apparent. In terms of some of the unique things that vets have to face on a daily basis, whether that is culling animals or helping farmers themselves in distress, there is research that we came across. The trauma of that obviously plays a key role in worsening mental health of those advisers and vets particularly.

Dr Hudson: We will in future sessions have veterinary bodies come in to talk to us as well. Touching on my colleague Robbie's questions about foot and mouth, there is the traumatic side of culling animals on farms that were completely wasted and did not go into the food supply chain. We are currently seeing that now in the pig sector—the heartbreak that goes along with that for all the people concerned.

Q46 **Chair:** Can I just add to what Neil has said? The problem too with the foot and mouth outbreak was that you saw herds of cattle that were slaughtered that had been bred for several generations—perhaps three or four generations. You had flocks of sheep that were the same. It is about the extent to which the services—the mental health services and others—can recognise that particular ordeal. To some people, cattle are cattle and sheep are sheep, but you have bred those for three or four generations and your whole stock has been wiped out. I know we had that in parts of Devon in particular where that happened, and it did in other parts of the country—Cumbria, Yorkshire and everywhere, really.

Is there a way we can get this recognised, not just with foot and mouth? I hope to God we do not get that again, but it may come. This is a general question, in a way. To what extent can we get the services to recognise those particular special needs? Do we need to feed more information into the services themselves for that special need?

Dr Rose: There is always more we can do with educating service providers to understand the unique nature of businesses. I would the point about farmers' very close relationship with livestock, their care and the passion they put into their work.

One of the things that came out in our research about the impacts of Covid was farmers having to go to auction marts with their livestock, drop them off and go away, not seeing them sold. We had farmers saying that just was not right. They cared for these animals for a long period of time. They wanted to be with them when they were sold. They felt like they were just dropping them off and going. That really made a lot of farmers struggle. Perhaps that was not really recognised. We did not

recognise how important it was for the farmer to stay at those auction marts, be with other farmers, and see who the livestock was sold to, where they went, and so on. Greater awareness of that importance of the relationship is needed.

Q47 **Dr Hudson:** I know we will be talking to vets in future about the support mechanisms, and we have talked about the NHS services as well. The vets have groups like the Vetlife Helpline and that side of things. Within the farming community—resilience and that side of things—can you give us a perspective of what communities in the rural sector are doing to help themselves, in different groups that are coming together?

Young farmers are doing things. I am aware that in Australia there is a group called Fat Farmers. That started because they wanted to get farmers to become physically well. It is not a very politically correct name, but actually it was a way of grouping people together to look after their physical health. They also worked out that it was about looking at their mental health as well. What lessons do we have here? Do we have good things happening in that sector?

Dr Rose: We came across wonderful examples. I am sure Dr Wheeler has examples of what different organisations are doing to help. We have some equally wonderful names. There is one group call Farmerados that works in the south-west.

One really good example that came out in a workshop of how to get farmers to open up about their mental health was being proactive but not talking about mental health in the first place. It could be stands at farmers' markets or village fêtes, where you can get farmers to open up about how their business is and the challenge they are facing; maybe you can have a mental health nurse there. Once they have started to open up, you can follow up and just say, "How are you?" and so on.

There were good examples of getting farmers to open up about mental health without seeming like they were talking about mental health. There are some great examples in young farmers' clubs and other examples of charities and chaplains who do this great work. There is lots to learn from.

Q48 **Dr Hudson:** Is there a role for DEFRA, Government and the Department of Health and Social Care to pump-prime some of these groups to get the help out there into the communities?

Dr Rose: Yes. The organisations that we spoke to, particularly the charities, said often they are competing for limited cake. Many of them are either competing for the same funds, or there is limited scope for collaboration and limited scope for long-term funding. A lot of organisations said that their staff had to keep doing things on good will, because the funding had stopped, but they really wanted to carry on because they were invested in it. I do not for one second think that it is DEFRA's role to start curating, co-ordinating and delivering this landscape of support. They do not have the trust that many of these organisations

have. More funding support and support of these organisations that do incredible work is the way forward.

Sarah Hughes: Perhaps DEFRA's role is about creating the ideas around what mentally healthy farming looks like. What does a psychologically informed service look like from a farmer's perspective? There are all sorts of things that can happen by listening to people who are living in those spaces and are experiencing that life every day. Maybe it is about shifting the dynamic here. We have heard from colleagues that grassroot peer support has often been the most helpful, so perhaps we need to focus on some of that, which again the integrated care systems can do.

Chair: Perhaps we will ask the Secretary of State and the agriculture Minister about the wellbeing of farmers and what they are going to do about it. It is an interesting point that we might be able to make to them. Thank you.

Q49 **Kirsty Blackman:** It is really interesting to hear the conversations about foot and mouth, which was such a huge thing, but in most professions you would not be talking about something that had happened 20 years ago. It would not be something that was still having an impact. Because of the generational nature of farming, it is the same families who have those farms and are still affected by the ripple effect of it. That is another different factor.

Specifically focusing on suicide—Rachel, perhaps this is one for you. Is the Government's funding and strategy for suicide prevention targeted effectively on the areas and jobs where the need and risk is highest? If it is not targeted most effectively, what improvements, tweaks or wholesale changes should be made in order that suicide prevention work is targeted more effectively?

Rachel Hutchings: I am not the right person to answer that question, I am afraid. I do not know whether Sarah has more insight on that particular strategy.

Sarah Hughes: It is again very variable. Local suicide prevention plans mandated are still fairly new. Ultimately, they are in development. Again, like all of the planning and guidance that we have, they do not suitably reflect the need of rural and coastal communities well enough. Again, national campaigns around suicide prevention do not necessarily land well in local areas. Every Mind Matters, for instance—the national campaign that we have—might not lend itself well to rural areas because of the way it talks about access to services and self-care, for instance.

We do have plans for a new suicide prevention strategy. Again, it might be that this Committee could invite the taskforce that is leading that work to come and talk about how that new strategy is going to meet the needs of rural communities in terms of suicide prevention, because at the moment it is probably not a priority or not prominent.

Q50 **Chair:** There is just one final point from me. It has been a really good

session. We are going to put a report together. We are building up the evidence. You are a very excellent start this afternoon. What one recommendation would you like this Committee to make to improve the issues we have been talking about today?

Dr Rose: I am not sure it is a recommendation, but perhaps asking DEFRA for more information. I would like you to ask the Secretary of State, the agriculture Minister or whoever is coming what they think their role is in this landscape of support. What are they intending to do? Are they intending to fund? Are they intending to co-ordinate? I have worked on lots of projects in all sorts of different agricultural topics over the years. I have always really been able to find the person or team in DEFRA that I can work with about an issue. For this issue of mental health, although there are a lots of people in DEFRA who are thinking about it, it has been really hard to find the team or the person who is taking this as the central issue. That is the problem. I would ask them to look at that and put more emphasis on it.

Chair: That is a good point.

Dr Wheeler: It is hard to choose one. I will go for one we have already talked about: improving the understanding within the medical profession in rural areas about the specific needs of farming and particularly the stuff about barriers. Part of that may well involve linking up with some Farming Help charities or at least talking to them about what that means. I hope that you are inviting some of them to talk in future sessions.

Chair: I am sure we will. That is a good point.

Sarah Hughes: I would like to see the needs of rural and coastal communities really highlighted in local integrated care system planning so that it is really held highly in terms of priorities, because those are the immediate levers we will have to improve people's experiences.

Rachel Hutchings: Sarah has actually just taken the recommendation that I was going to make.

Chair: That is the only trouble with coming last..

Rachel Hutchings: I would echo what Sarah has said, but I would also draw attention, from a service perspective, to the fact that a lot of these issues that we have highlighted have been systemic ones that the NHS in particular has been facing for a long time. Just picking up on the last discussion around resilience, it is really important to think about how we address those issues going forward so that we build resilience into the system and people are able to access support when they need it.

Linked to that, when we are talking about workforce, funding and infrastructure, we really need to make sure that we are considering the particular needs of rural communities within those broader conversations in the context of healthcare.

Chair: Thank you very much. It has been a really excellent session. It

has started us off very well, really drilling down on the problems with mental health. I think it was Rachel and David that may have looked in the room because it was your first time to come before a Select Committee. I know it was for you, Rebecca, as well. I hope it has not been too traumatic. Thank you very much for the excellent evidence. It has been really good to see you here in person. Sarah, you have fared well being online. You have got your points over very well and we have much appreciated having you online. I hope your Covid gets better soon. Thank you for attending online.

It has been really good. It is a very emotional subject. It is quite emotional for me because I have had personal experiences within my own family, as many have. I hope that when we finalise it all, we can put together a very good report. You have given us a good overall picture of how we can conduct our inquiry. I thank Andy very much for putting the brief together and pulling it all together. With that, we will finish the meeting. Thank you very much.