Written Evidence submitted bt the Centre for Mental Health (MH37)

Introduction

Centre for Mental Health is an independent organisation dedicated to eradicating inequalities in mental health. Our work includes research, analysis, advocacy and training. We have collated in this paper evidence gathered from our work and research we have reviewed which may be relevant to the Committee's inquiry.

We have reviewed evidence relating to children (predominantly those aged 8-13) living in rural and coastal communities UK wide (Allwood, L. 2020, *The space between us* https://www.centreformentalhealth.org.uk/publications/space-between-us). The evidence shared in this paper is drawn from that research, except where indicated otherwise, and all references cited are available in the full report.

1. What specific mental health challenges are faced by those living and working in rural communities?

Mental health needs/prevalence

Research points to a number of positives to life in remote and rural areas. Compared to urban populations, people living in rural areas report a stronger sense of belonging and community than urban populations (Department for Environment, Farming and Rural Affairs, 2019a); less social isolation and more social relationships (Henning-Smith et al., 2019); better neighbourhood environments and higher levels of subjective wellbeing (Bailey et al., 2016; Nicolson, 2008). Evidence from Scotland and Ireland suggest higher levels of life satisfaction in rural and remote areas (Gilbert et al., 2016; Brereton et al., 2011).

Young people in rural England receive fewer school exclusions and have lower emotional and mental health needs than their urban counterparts (based on a study on 15 year olds), but conversely, young people display more 'risky behaviours' which include alcohol consumption, smoking and bullying/ being bullied (Rural England, 2018).

An Office for National Statistics investigation into childhood loneliness found that a higher percentage of children in cities reported loneliness (19.5%) than did in towns (5.4%) or in villages, hamlets, and isolated rural locations (5.7%). This investigation found that loneliness was not defined by children by space or place, but by a sense of exclusion, disconnection from others, unhappiness with relationships, or punishment. Regardless of location, those most at risk of experiencing loneliness were identified as children with long term health conditions or disability (ONS, 2018; ONS, 2019).

Poor public transport and infrastructure has been associated with negative wellbeing in remote communities in numerous rural studies (Sadler et al., 2014; Glendinning et al., 2003; Shucksmith, 2004; Gristy, 2019; County APPG, 2017).

Economic and social inequality

There is evidence from rural and remote areas in England that deprivation is felt more acutely by those who live close to largely affluent populations (e.g. those living in the Fenland versus Cambridge itself; Sadler et al., 2014). A study of rurality and young people in Northern Ireland suggested that the close proximity of deprived neighbourhoods to very

affluent areas can lead to further social exclusion and marginalisation (Education Authority, 2019a).

One English study suggests that there are 'two countrysides': one which is better off and another which is less populous and more isolated (Pateman, 2011). This might be exacerbated in areas of natural beauty which attract buyers of second homes or holiday home rentals, creating affordability challenges for the resident population. Research based on 28 villages in Northamptonshire identified 'an alternative geography of exclusion and disenfranchisement' where the least well off children and teenagers were more likely to feel detached from village life and felt a strong sense of alienation and powerlessness (Matthews et al., 2000).

Access to support

Children living in remote areas face significant barriers to accessing support. These are disproportionately experienced by children living in poverty, children who have complex needs and children who face other risks of exclusion, alienation and marginalisation – for example young carers, disabled children, children from Gypsy, Roma and Traveller communities, and children whose gender or sexual identity is different than most of their peers.

Organisations delivering services in rural and remote areas face significant challenges in accessing funding, premises, and personnel. Funding is, of course, a challenge for many organisations who have previously relied on public money which is no longer available, as evidenced by the closure of Sure Start centres, libraries and public transport routes. Premises are difficult to maintain without sustainable funding, and there can be limited options for children in spaces which must also meet the needs of the wider community (for example, it can be difficult to maintain anonymity if receiving mental health support in a building used by other groups). Transport to these spaces can also be a challenge.

It is harder to recruit and retain skilled professionals in many remote areas. Rural and remote projects often rely on volunteers for their coordination and delivery. Volunteers are an asset, but they also need support and training which can be difficult for small organisations to afford or source.

The idea of using libraries as community hubs in rural areas, giving access to the internet or space for clubs, physical activities, baby groups and children's activities, is increasingly popular in many local areas (Thomson and Murray-Sanderson, 2017). This was a theme in responses to a Scottish Government consultation on social isolation and loneliness. Children and family support practitioners called for investment and support for community hubs, longer opening hours and weekend opening of existing community spaces, and co-location of a range of services to help people come together for social, physical and cultural activities (Stepping Stones for Families, 2018). However, due to local authority cuts, almost one in five community libraries has closed over the last ten years in England, Scotland and Wales (CIPFA, 2018).

2. **What is the current state of mental health & suicide prevention service provision for those working in agriculture and those living in rural areas more generally? Do they meet the specific needs of that community?**

Remote areas appear to be particularly badly served by specialist mental health services. For example, the majority of seaside towns and coastal communities in England have no access

to specialist child and adolescent psychotherapy, despite being associated with poor mental health and high rates of harmful behaviours (Association of Child Psychotherapists, 2018).

The struggle to attract skilled professionals to these areas may be partly to blame, with geographical isolation, poor infrastructure and lower wage prospects seen to discourage potential recruits (Select committee on regenerating seaside towns and communities, 2019).

The Care Quality Commission's review on the quality and accessibility of children's mental health support in England (2018) concluded that services offering prevention, early intervention and promotion of good mental health are vitally important for children and young people. Without this low-level support, pressure on CAMHS waiting lists could continue to rise. However, too often the provision of low-level, proactive support is side-lined by the urgent need to address waiting times directly by providing more or investing in specialist CAMHS. There is evidence, too, that poor access and long waiting times in specialist services drive children and young people to seek help locally from voluntary sector organisations, which find themselves working with children with more severe mental health needs (NICCY, 2018).

Local authorities have a key role in supporting voluntary organisations through grants, contracts and resource sharing. There is already significant variation in spending on children's support across the country. Funding available for youth centres in England has fallen by a third since 2010 (Action for Children, 2019). In the same period, the number of Sure Start centres also decreased significantly. Research by The Sutton Trust suggests that nearly a third of children's centres were closed – with some areas sustaining deeper cuts than others and the number of services available in centres also diminishing significantly (Smith et al., 2018).

Children who live far from statutory mental health services face much longer travel times and increased costs to access support. For some, the cost alone can be prohibitive. In a review of provision in England, the Care Quality Commission identified this as an issue that prevents some children from accessing emotional wellbeing support when they need it, leading to cases where individuals' mental health deteriorated over time and required specialist treatment (Care Quality Commission, 2018). These treatments are even less likely to be delivered close to home.

Poor transport infrastructure can be a challenge for practitioners trying to reach out to the most vulnerable children in communities (Education Authority, 2019a). Given the distances involved in travelling to young people or transporting young people to a centre, a lot of time can be lost in transit during the delivery of youth work. Despite this recognition, there are signs that transport services are getting worse for many remote communities.

Finally, it has been suggested that the invisibility of mental health support in rural areas leads to the belief that services are not available, which means people do not seek help for their own or their child's needs:

"Rural Mental Health Matters (RMHM) found that the perception is, if people do not 'see' services in their community, they believe they are non-existent. This has led to a culture of self-reliance and stoicism towards mental health issues which can prevent people from seeking support earlier, instead only seeking support when they have already reached 'crisis' stage.' (Centre for Mental Health guest blog by Melanie Costas

https://www.centreformentalhealth.org.uk/blogs/unseen-and-unheard-tackling-inequality-rural-mental-health)

3. **What are the causes of the higher than average rate of suicide amongst those working in agriculture? Are there other linked professions, such as vets, that have similar issues? How effective are suicide prevention services offered to these groups?**

We don't have specific evidence to answer this question

4. **Is sufficient mental health support made available to rural communities following "shocks" such as flooding or mass animal culls?**

There is strong evidence that floods lead to both immediate and sustained damage to people's mental health, with the biggest effects felt by those worst affected and those with the least resources (for example those without insurance in high flood-risk areas).

Traumatic events put people's mental health at risk long-term, so mental health support needs to be available over time, not just in the immediate aftermath.

Research on extreme weather events (Cruz et al., 2020) found that flooding brings an increased risk of depression, anxiety and trauma symptoms, months and years later – and can be triggered by similar events, eg heavy rainfall:

"The long-lasting effect of flooding, from 6 to 24 months after the event, was described in several studies of flooded communities. This was illustrated by increased visits to GP practices and hospital referrals 12 months after the flood, and by participants self-reporting on-going psychological distress. The risk of long-term mental health problems was reported to be between four to 8.7 times as high for flood victims compared with non-flooded subjects. Even years after the event, respondents affected by flooding experienced anxiety during heavy rain. Anxiety was associated with increased levels of stress, sleep problems, panic attacks, difficulty concentrating on everyday tasks, lethargy, nightmares, anger, mood swings and increased use of alcohol or prescription drugs or antidepressants…

'The observed prevalence rate of PTSD among populations exposed to flooding in the studies included in this review (30.4%) is substantially higher than the lifetime prevalence rate of 7.8% observed in the general population"

(Cruz et al, 2020 https://www.mdpi.com/1660-4601/17/22/8581/htm)

The same study also found socio-economic factors affected people's chances of their mental health being harmed by flooding (with the risk greater for those with the least resources), as did the response of government agencies before, during and after the event:

"Home ownership, as an indicator of income, was linked to lower levels of poor mental health when compared with those in rented accommodation. Those with lower income levels, unemployed, economically inactive and those with prior medical conditions were more likely to experience deteriorations in their psychological health after exposure to flooding.

Other financial factors, such as problems with insurance companies or a lack of insurance, were associated with increased levels of stress immediately after flooding. Lack of support from different authorities before, during and after the floods, which led consequently to a

loss of confidence and trust, was also highlighted by the flood victims as hindering their mental recovery and increasing their levels of anxiety."

(Cruz et al, 2020 https://www.mdpi.com/1660-4601/17/22/8581/htm)

5. **Does the Government's recent investment in mental health services adequately provide for rural mental health?**

The NHS Long Term Plan mental health implementation plan and the Community Mental Health Framework make no specific mention of rurality. They do, however, encourage local systems to adopt a 'place based approach' to meet local needs: unlike many previous plans there is not a fixed 'model' for community mental health support. This has encouraged some areas (eg Somerset and Cambridgeshire & Peterborough) to be innovative in their use of transformation funding, working alongside the voluntary and community sector and local government to provide a more integrated and comprehensive range of services.

Hidden poverty is a major concern with regard to investment in mental health. People in coastal towns, rural settlements and remote areas are more likely to experience high levels of deprivation, but this can be concealed – and exacerbated – by nearby areas of relative wealth and privilege. The visibility of rural poverty is further obscured by traditional tools for measuring poverty and deprivation which are not refined enough to identify areas where this is dispersed or present in small pockets. This means allocation systems for public funding risk overlooking areas of high deprivation within largely affluent regions.

6. **How joined up are key actors, such as Defra, DHSC, NHS England, Public Health England and Local Government in their approach to improving quality of, and access to, mental health service in rural and agricultural communities?**

We don't have evidence specifically related to this question.

Implications and recommendations

Centre for Mental Health believes that we need to redesign systems with equality in mind. Mental health inequalities are too easily ignored or taken for granted. They very largely mirror economic and social inequalities in society, and for many people there is a triple barrier: those facing the greatest risks to their mental health very often have the least access to support and the poorest outcomes (Commission for Equality in Mental Health, 2020, *Mental health for all?* https://www.centreformentalhealth.org.uk/publications/mental-health-for-all).

This is as much the case in rural and coastal Britain as elsewhere: the most disadvantaged, marginalised and oppressed are at higher risk of poor mental health but less likely to get access to effective help. But there are additional barriers for people in rural areas, including the invisibility and inaccessibility of support – both to prevent mental health difficulties or to provide help when it's needed – and people whose needs are not met are equally invisible to services.

While high quality evidence about mental health needs in rural areas and how best to meet them is sparse, what we do know would lead to recommendations including:

- The Government's new ten year mental health plan should include action across departments to address the causes of poor mental health in rural as well as urban

areas of England. This may include taking steps to prevent damage from climate related disasters (such as flooding and coastal erosion) and to protect uninsured households.

- The Government should invest in prevention and earlier help for children and young people's mental health in rural areas: for example supporting the expansion of Family Hubs, boosting Health Visitor numbers to enable them to provide mental health support to new mothers, enabling schools to adopt the 'whole school approach' to mental health, and funding Early Support Hubs for young people (such as MAP in Norfolk)
- NHS England should ensure that mental health services are developed with rural areas in mind, providing adequate funding for adaptations to service provision to meet the needs of dispersed populations and especially the most deprived rural communities. It has an opportunity in refreshing the NHS Long Term Plan to encourage integrated care systems to 'rural-proof' mental health care
- Integrated Care Systems that include rural areas should seek to adapt mental health provision in those places to ensure equity of access, experience and outcome. This should include a consideration of inequalities – for example ensuring access to support is not dependent on having private transport and is accessible to children and young people
- Policymakers and commissioners need to direct resources into pockets of poverty and disadvantage in rural areas. Current models mean localised areas of deprivation are overlooked and opportunities are missed to meet people's needs more effectively.

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