Written evidence submitted by the National Rural Mental Health Forum (MH0022)

The National Rural Mental Health Forum was set up by Support in Mind Scotland (SiMS) in 2017. SiMS has 50 years' experience in tackling mental health, employs around 150 people and supports up to 1700 individuals every week, of which 80% are in rural communities. www.supportinmindscotland.org.uk

SiMS is also a partner in Mental Health UK, whose other partners are Rethink Mental Illness (England), Mindwise (Northern Ireland) and Adferiad Recovery (Wales). Mental Health UK brings together the heritage and experience of four charities from across the country who've been supporting people with their mental health for nearly 50 years.

Mental Health UK - Forward Together (mentalhealth-uk.org)

The National Rural Mental Health Forum has around 220 membership organisations, many covering all of the UK. Those member organisations are from third, public and private sectors. The Forum raises awareness, tackles stigma, encourages collaboration, promotes partnerships, furthers research and informs policy: www.ruralwellbeing.org

The National Rural Mental Health Forum is an action of the Scottish Government's Mental Health Strategy (Action 12), is included in the Mental Health Transition and Recovery Plan (3.3) and the Suicide Prevention Strategy.

The Convener of the National Rural Mental Health Forum also chairs The Worshipful Company of Farmers' Health and Wellbeing Forum, which involves support organisations from across the UK.

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

There are a number of points to highlight with respect to rural areas that provide important **context for mental health challenges**. We explore these first and then move on to the challenges themselves.

The diversity of rural: it is important to note that "rural" is not a homogenous area; it comprises a mix of remote and accessible areas (in terms of geographical location, services and infrastructure), as well as mainland and island locations. These differences affect the extent to which individuals or communities experience rural as either connected or disconnected. This sense of being connected or not also varies greatly with the seasons. For some, winter is a time of connection, since this is when many of the classes take place; for others, winter can be a time of isolation due to poor weather, dark days, fear of leaving home and/or driving due to very limited public transport.

Layering of experience: people's rurality is also directly affected by their own mobility, determined by their socio-economic resources (disposable income and connections), as well as on their physical and mental wellbeing. People with fewer resources overall experience greater isolation, which is then exacerbated by geographical remoteness and poor services/infrastructure. This is the *"layering" effect of rural life*: personal and physical/geographical factors build on top of each other, making someone feel either more lonely or better connected. For example, if you can't drive, can't afford a car, and you are physically remote with limited public transport, then your isolation is significant, with direct impacts on mental wellbeing.

Dispersed nature of poverty and disadvantage, and mental ill health: the usual tools for measuring disadvantage (Index of Multiple Deprivation) do not fit rural areas, since in rural UK *people not places experience poverty*. Individuals can live in poverty right next door to those living in wealthy circumstances. There are not "pockets of poverty" in rural areas as in urban centres; rather, single families face poverty and ill health (physical and mental). Hence poverty and disadvantage, and particularly multiple interlinked disadvantage, are not picked up in statistics that rely on *areas* to define communities facing challenges. This means that people fall through the cracks of multiple challenges: poor housing, fuel poverty, joblessness – all combining with mental ill health and poverty. Two-thirds of people living in deprivation do not live in an area of multiple deprivation, people experience deprivation, not places.

Lack of anonymity: A particular characteristic of rural life is the fact that people live their lives very "visibly" in front of their neighbours, even though such neighbours may be many miles away in some instances. They meet in the Doctor's surgery where the Receptionist may be a relative of someone they know; the shop or Post Office may be run by relatives or friends, as might the pharmacy, social work, citizens' advice or other support centres for drugs, cancer or counselling support. Accessing these places often requires meeting known faces, friends-of-friends or family members. Evidence shows that people therefore present later, or not at all, meaning that conditions reach crisis point before people seek help.

Resilience in the face of challenges: there is an expectation in rural areas that, in the face of growing challenges, individuals will be resilient and strong, finding their own solutions. These challenges include declines in public transport, service provision (particularly specialist physical and mental health services), shops and meaningful jobs with progression routes, as well as a significant and systemic lack of affordable housing. It is necessary to remain resourceful in the face of these challenges, with the focus on creating solutions. This can create pressures on individuals and communities to come up with the answers, e.g. to provide their own broadband and community centres, keep GP centres open etc., when such an expectation would not be held for individuals and communities in towns and cities. This can cause "burn-out" in many communities with an associated sense of being left to battle alone to keep vital communities and resources alive.

The myths of rural life as an idyll: there are versions of "rural" as somewhere that people move *to* in search of an idyllic lifestyle (even more so with lockdowns/working from home that have seen rural house prices escalate significantly), and to move away *from* if things get too challenging. However, not everyone finds rural to be their idyll, particularly as they age and have need of services close to hand; and not everyone has the same means or desire to move away from what was once home to a town or city. Both of these migrations can and do lead to mental health challenges as the myths around rural continue, rather than the realities of rural challenges being addressed through meaningful, strategic support with and for rural communities.

Specific **rural** mental health challenges include:

- Mental ill health is an **invisible illness** – made more invisible by being rural and remote (SRUC/SIMS 2017; Prince's Countryside Fund, 2018). This invisibility increases for those who have **protected characteristics** in rural areas, for example, those who identify as **LGBTQI+** (Equality Network Scotland, 2021), as well as **refugees, asylum-seekers and migrant workers** (SIMS, 2021).
- Conversely, it is a **visible condition** inasmuch as people must seek help publicly (as stated above) via healthcare channels, in the knowledge that family and friends are likely to find out. This leads to people presenting either later or not at all, when it can be too late to provide meaningful help and support.

- **Stigma:** many in rural areas experiencing mental ill health do not feel they can be open about their mental health problems within their own community. While openness has increased greatly over the past five years, stigma still persists.
- **Public transport:** this acts as a barrier to receiving proper care needed to manage mental health, a situation which worsened for those reporting suicidal thoughts and feelings, and self-harming behaviour. This can lead to a "layering" of isolation factors.
- **Lone working and social isolation:** evidence shows that many of the occupations in rural areas are based on self-employment or micro-enterprises with extended periods of lone working meaning little/no contact with others. This means that any concerns or worries about the business cannot be talked through readily with others, with any solutions appearing out of reach. Amongst the **farming population** in particular, there has long been a concern at the levels of mental ill-health and suicide, particularly males and those in "low-skilled" jobs (offering low pay and security). The suicide rate for farm workers is twice that for all occupations (ONS, 2016). For those involved in agricultural and fishing trades, a category that includes gamekeepers and foresters, the rate is more than three times the average for all occupations (ONS, 2016). Evidence suggests that there is **under-reporting of suicide** amongst the farming sector, due to part-time farmers not being recorded in the statistics, suicides being reported as accidents, as well as statistics on suicide by occupation only including those up to the age of 65, meaning that farmers who continue working beyond traditional retirement age are excluded. Further, data held by Public Health England (e.g. on suicide attempts, self-harm etc.) cannot be broken down by occupation.
- **Access to the means to end one's life:** the land-based sector (farmers and vets) has ready access to chemicals, medication and firearms in the course of their work. This means that at crisis point, it is possible to end one's life by suicide more readily.
- **The pressure to be resilient and strong within the rural community or family business:** due to the public nature of life in rural areas, and often the family pressures associated with living and working in the local community and often in/with the family business, there are pressures not to be the person (or "generation") that fails. This carries enormous public pressure within tight-knit rural communities that can be judgemental around success or failure, causing farmers not to seek help or to postpone seeking medical or other support.

QU.2. What is current state of mental health and 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?

The 2017 research (SRUC/SiMS, 2017) evidence showed that those experiencing mental ill health in rural areas need to be receiving **pre-crisis** support, in **non-clinical settings** within their **own communities**. However, the dominant model still points to those with poor mental health being asked to travel to mental health services (labelled as such) in centres of population where sufficient numbers of "clients" justifies ongoing provision, often via limited public transport. This is not a sustainable model for small numbers of dispersed rural populations, particularly those with specific needs and/or who may have protected characteristics. Investment and design *with* those experiencing mental ill health needs to be undertaken to support provision *within* rural communities in new ways that involve community-based individuals. Communities can be place-based, but also work-place and interest groups.

Mental health and also suicide intervention training are valuable resources to build resilience in communities and the workplace. Covid has had the effect of some training being unavailable and organisations have developed their own online programmes. The National Rural Mental Health Forum believes that ideally everyone should be able to access this training when needed, so that communities can look out for each other and intervene at the earliest point of someone experiencing poor mental health.

Such successful ways of working that are delivering positive outcomes within rural areas, are being shared through an innovative national network in Scotland. The **National Rural Mental Health Forum** (established in 2017 by SiMS) now has around 220 organisational members with a reach to over half of Scotland's rural population and has members with a UK-wide coverage. The Forum is involved in exchanging best practice, reducing stigma, carrying out research through partnership, and informing national policy. This collective approach allows rural specifics and learning to be fully taken into account – from community to central policy-making – and is changing how rural mental health is tackled across the public, private and third sectors.

Link to National Rural Mental Health Forum: www.ruralwellbeing.org

QU.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?

Stressors/factors affecting farmers' wellbeing – how these combine will impact farmers' mental health:

- Security of tenure: owner or tenant, contractor;
- Economic stability or fragility: market supply and demand; farm gate prices; changing subsidies and associated uncertainty; Brexit impact; changes in regulations; cost of credit/liabilities (especially if operating at a loss);
- Changing weather patterns; climate and impact of seasons on production; animal diseases;
- Length of working week/number of hours worked; lack of holidays; exhaustion leading to poor decision-making and associated consequences;
- The pressure to maintain the family farm, and to hand on the farm to the family successor, NOT to be the generation that fails.

Vets in particular:

- High pressure work environment;
- Pressures from farming community, looking after people's loved animals, trying to save lives
- Access to means/medication

Measuring the effectiveness of suicide prevention and intervention can be difficult, as there are many factors at play. But there is evidence that interventions, such as limiting quantities of paracetamol bought at one time (for general public) and the use of blister packs has reduced suicide by paracetamol poisoning.

QU.4. Is sufficient mental health support made available to rural communities following "shocks" such as flooding or mass animal culls?
Not answered

QU.5. Does the Government's recent investment in mental health services adequately provide for agricultural mental health?
Not answered

QU.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?

The National Rural Mental Health Forum works across different Government portfolios and believes that all departments should take into account mental health in their decision making, i.e. Mental Health Proofing of policy and decisions made. The Forum and its members (www.ruralwellbeing.org/partners) believe it is everyone's business to tackle mental health.

The Worshipful Company of Farmers' Health and Wellbeing Forum has convened meetings with Public Health England and Defra to explore improvements in rural mental health. More can always be done.

Sources:

Mental Health Strategy 2017-2027 **Mental Health Strategy 2017-2027 - gov.scot (www.gov.scot)** **Action 12** Support the further development of the National Rural Mental Health Forum to reflect the unique challenges presented by rural isolation.

Scottish Government Suicide Prevention Action Plan **Suicide prevention action plan: every life matters** The "National Rural Mental Health Forum … is key to addressing the unique challenges presented by rural isolation".

Covid Mental Health Transition and Recovery Plan **Coronavirus (COVID-19): mental health - transition and recovery plan - gov.scot (www.gov.scot)** **Ensuring Equity and Equality 3.3** Although there are many positives about rural life, we also recognise that there can be challenges relating to rural isolation. These may be increasingly felt by those in remote communities as a result of the pandemic. In partnership with the National Rural Mental Health Forum, we will develop an approach to ensure that these communities have equal and timely access to mental health support and services, including consideration of whether dedicated pathways are needed.

Equality Network Scotland, (2020), Further Out: The Scottish LGBT Rural Equality Report

Prince's Countryside Fund (2018), Recharging Rural Report

Scotland's Rural College (SRUC) & Support in Mind Scotland, (2017), National Rural Mental Health Survey Scotland: Report of Key Findings

Support in Mind Scotland, (2021), Marginalised Rural Communities

The Worshipful Company of Farmers, (2019), ***Health and Wellbeing Research Report – Farmers and Farming Communities***

University of Edinburgh (2021), *Impact of Covid on Rural Scotland: CovidLife | The University of Edinburgh*

The WCF Health & Wellbeing Initiative | Health & Wellbeing | The Worshipful Company of Farmers (farmerslivery.org.uk)

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