Briefing: Mental Health in Rural Scotland: Assessing the evidence base and the next steps for service provision

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Summary

Mental health is a major public health issue in Scotland, with around one in three people being affected by mental illness. Improving mental health services is a key policy issue. There is also growing recognition that rural contexts, whilst a core component of addressing mental ill health, have been widely overlooked in Scotland. This led to the creation of the National Rural Mental Health Forum, which Scottish Government has subsequently supported. Specific rural clauses were also included in the Mental Health Strategy, which was refreshed in March 2017 Finally, a report jointly produced by Scotland's Rural College and Support in Mind Scotland was released earlier this year which provided unprecedented perspectives on the experiences of people suffering from mental ill health who live in rural Scotland. This briefing outlines the methods and main findings of this report and is of interest to all local authorities with significant rural areas.

Briefing in full

Background

A core challenge to addressing mental health issues in Scotland is accounting for the experiences of those living in rural areas. However, this population has typically been the subject of precious little research. Prior to 2017, the understanding of rural people's experiences of mental ill health in Scotland had largely been anecdotal and based on individual cases (primarily in the farming community). It is well-known that policy intervention in rural contexts requires a tailored approach, but the dearth of information on rural mental health has frustrated attempts to discern rural-specific concerns, issues and opportunities.

To address this knowledge gap, and to ensure that sensitivities around this issue were appropriately handled, the Rural Policy Centre at Scotland's Rural College (SRUC) formed a partnership with national mental health charity Support in Mind Scotland (SiMS), whose service provision is primarily in rural Scotland, in 2016. The partnership then conducted a mixed-methods study that culminated in a first-of-its-kind report released in April 2017.

Methods

SRUC and SiMS began by holding two workshops in June 2016, in Inverness and Dumfries. These brought together service users with providers, along with a breadth of rural organisations – a combination of people who would not typically meet. Participants were asked to identify uniquely rural characteristics when experiencing mental ill health in rural Scotland (as either service users or providers), and if so, the priorities for these issues.

These scoping workshops provided background evidence for building the subsequent survey which included both closed and open-ended questions. The survey (available online and offline) was specifically targeted at those experiencing mental ill health in rural Scotland, and was publicised through the membership database of SiMS, professional networks of SiMS and SRUC researchers and social media (primarily Facebook and Twitter). Crucially, the latter enabled researchers to target areas with low response rates, which led to increased responses from under-represented areas over the four-week survey period.

Main findings

Survey Sample

343 people experiencing mental ill health across rural Scotland responded to the survey, covering 94 postcodes across the country (with the most responses coming from Dumfries and Galloway). While the respondents were predominantly female (273) the number of male respondents (70) is encouraging because men are typically under-represented in terms of disclosing personal feelings and concerns about mental health. The majority of respondents were in the 45-54 age cohort, but a relatively high proportion of responses (50) came from people aged 16-24, which provided rich evidence on the experiences of young people experiencing mental ill health in rural Scotland. Finally, the majority of respondents (214) were employed, self-employed, or on government training, with 37 unable to work and 27 in full-time education.

This respondent profile was unusual because the typical clientele for SiMS (as well as similar mental health charities whose main function is outreach, support and service provision) are those who are unable to work due to their mental health condition(s). This survey has therefore generated useful data in terms of those who are in paid employment who are also experiencing mental ill health challenges, as well as for those who remain unable to work.

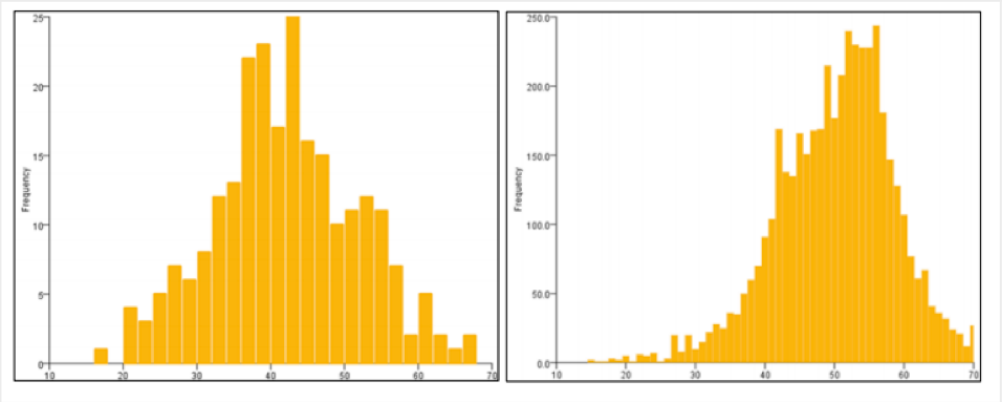
Respondents' self-reported mental wellbeing

Respondents were asked to indicate their mental wellbeing in two ways.

The first was giving their scores on the Warwick-Edinburgh Mental Wellbeing Scale to 14 positively-worded items

(e.g. “I’ve been feeling optimistic about the future”, “I’ve been thinking clearly”) with five response categories (from “None of the time” to “All of the time”) which are validated for use in Scotland. Notably, the results of the SRUC/SiMS survey responses for rural Scotland are ten points lower than the figures found by the 2014 Scottish Health Survey, a statistically significant difference (Fig.1)

Figure 1: Warwick-Edinburgh Mental Wellbeing Scale, SRUC/SiMS survey (left) and Scottish Health Survey 2014 (right)



Source (p.22)

The second way respondents indicated mental wellbeing was through self-reporting whether they had any of 15 recognised mental health issues, to which they could respond as few or as many as were relevant. The conditions listed in the survey were:

- Generalised anxiety disorder
- Social anxiety disorder
- Phobias
- Depression
- Bipolar disorder
- Schizophrenia/psychosis
- Dementia
- Anorexia
- Bulimia
- Binge eating disorder
- Obsessive-compulsive disorder
- Post-traumatic stress disorder
- Stress response syndrome or adjustment disorder
- Suicidal thoughts and feelings
- Self-harming behaviour

The data were broken down by issue and postcode area (Fig.2). The highest number of respondents for self-reported mental health issues was 197 people reporting depression (67% of the sample), 87 reporting generalised anxiety disorder (29%), 64 reporting suicidal thoughts and feelings (22%), 53 reporting social anxiety disorder (18%) and 35 reporting self-harming behaviour (12%). That this survey took place during August-September 2016 is important because anecdotal evidence indicates that some mental health issues, such as depression, are worsened during the winter months, particularly in northern areas, due to shorter daylight hours.

Figure 2: Geographical distribution of respondents’ self-reported mental health issues by postcode

Rural Postcode areas	Number of respondents	Number of responses per self-reported mental health issue, per postcode area				
		Depression	Generalised anxiety disorder	Suicidal thoughts and feelings	Social anxiety disorder	Self-harming behaviour
Aberdeenshire (AB21-56)	29	13	11	4	4	3
Forfar, Glamis, Kirriemuir (DD8)	3	2	1	2	1	2
Dumfries and Galloway (DG1-DG16)	62	28	16	13	13	7
Midlothian & East Lothian (EH16-EH34)	12	9	4	4	2	3
Menstrie (FK11)	1	1	0	0	0	0
Isle of Lewis (HS1 & HS2) Isle of Harris (HS3) Isle of Barra (HS9)	10	4	1	2	1	0
Highlands and Moray (IV2-IV63)	43	18	12	12	7	7
East and South Ayrshire (KA6-KA27)	9	3	6	2	2	0
Highland (KW1-14) Orkney (KW15-17)	41	21	15	9	6	4
Fife (KY2-14)	11	5	3	1	2	1
Renfrewshire and Argyllshire (PA7-PA76)	13	7	4	2	5	2
Perthshire (PH1-11) Highland (PH26-50)	22	13	5	5	1	1
Scottish Borders (TD2-TD14)	18	9	3	5	5	3
Shetland Islands (ZE1-ZE3)	22	11	6	3	4	2
TOTALS	296	197 (67%)	87 (29%)	64 (22%)	53 (18%)	35 (12%)

Source (p.23)

Interestingly, percentages of both men and women self-reporting the 15 mental health conditions were nearly identical, which raises two key points. First, women are reporting proportionately as much of these conditions as men, whereas anecdotally, conditions such as depression and suicide are seen as “male”, particularly in a farming context. Secondly, whilst men are (again anecdotally) not as open about mental ill health issues, this survey revealed high proportions of men reporting these conditions. The data therefore highlights the fact that the picture is more complex than the anecdotal evidence would suggest for respondents in rural Scotland.

Finally, there is no stand-out pattern to the most frequently self-reported issues and their relationship with respondent’s age. This is an important finding because (yet again anecdotally) the perception might typically be that self-harming is associated with younger people and depression and suicidal thoughts with older people. However, the data from the rural respondents show this not to be the case.

Respondents’ geographical location versus perceived geographical remoteness

The analysis of the survey data shows that there is no clear link between a respondent’s actual geographical remoteness and their perceived geographical remoteness, except in the case of those respondents who live in areas classified as “Remote Rural” according to the Scottish Government’s six-fold Urban-Rural Classification. For example, over half of those respondents who live in Accessible small towns also consider themselves as geographically remote, as do 80% of those living in Remote small towns and 50% of those respondents living in Accessible rural Scotland.

Also examined was whether there were any links between the top five self-reported mental health issues and public transport access. This data revealed that for those self-reporting **suicidal thoughts and feelings**, more than double stated that public transport did act as a barrier compared to those who stated it did not. For those self-reporting **self-harming behaviour**, three times the number of people stated public transport was a barrier than those stating it was not. This is crucial because the perception of geographical remoteness, coupled with these barriers of accessing mental health care via public transport, can lead to a “layering” of remoteness and isolation for people experiencing mental ill health in rural areas.

Community support and connections

Respondents were asked whether they felt they lived in a supportive community. More than three times the

number of respondents said that they “could get some help but they could help me some more” or that “my community is not supportive of me”, compared to those who said their community is “completely supportive”. They were then asked to consider a non-life-threatening situation regarding their mental wellbeing, and whether they could rely on members of their community to assist them. This revealed a similar pattern as above, with the majority responding that they were “not sure” or that members of their community “would not assist” them. These findings were compounded by the fact that twice the amount of respondents stated that they could not be open with their own community compared to those who said they could be open. Finally, just 20 respondents reported using a public space to socialise with other people experiencing mental ill health, compared to more than six times as many who said they did not.

The data thus reveal a picture that is specific to the experiences of those with mental ill health in rural Scotland. Namely, “community” is not always sufficient as a support network, nor are the majority of respondents engaging with similar people in shared spaces. These concerns are crucial because they could be substantially exacerbated by lack of access to treatment and perceived geographical remoteness as stated above.

These findings were supplemented by the qualitative data, where two themes emerged. Firstly, in relation to the local community of the respondent, familiarity and closeness appear to be a “double-edged sword” – providing comfort, security and homeliness to some, whilst being claustrophobic and judgemental for others. Secondly, those who found the community setting to be a disadvantage mentioned the distance they experience from close friends and family – meaning that their local community is not sufficient to provide what they need compared to less-accessible friends and relations.

Summary of Key Messages

In addition to the quantitative data, this survey concluded with two open-ended questions to give respondents the opportunity to reflect and communicate thoughts in greater depth. The questions, and summarised responses to them, can be found below:

“If you could change one thing about mental health services in rural Scotland, what would that be and why?” (p.45)

1. Create ways for people to connect before personal crises occur.
2. These connections need to be “low-level”, non-clinical, informal and through trusted people and networks.
3. Services need to be close to place of need – including mobile services, outreach, particularly on islands (i.e. recognising significant stress of travel to appointments.)
4. Mental health care must be mainstreamed within NHS – not a “bolt-on”.
5. There must be parity of mental health care with physical health care.
6. Increase the focus on children and young people (particularly in relation to self-harm) and reduce waiting times for them to be seen.

“What key message do you want to tell policymakers to help you manage your mental ill health in a rural setting?” (p.53)

1. It is an invisible illness – made more invisible by being rural and remote.
2. Listen to, and respect, service users.
3. Mental ill health does lead to death – it is a serious issue.
4. Shorter waiting times to see specialists are necessary.
5. Support low-level contact out with hospital environments, close to communities

Comment

This research has presented the hitherto unexplored views of those experiencing mental ill health in rural Scotland. Further, it has outlined significant complexities around the extent to which respondents feel that their communities are supportive of them. This is vital in terms of overcoming social isolation and addressing issues of stigma and

prejudice. It is also important due to the direction-of-travel, in policy and practice, towards community-based health and social care. There is work to be done in understanding how to engender and support well-connected communities so that they can provide the appropriate “low-level, non-clinical, local, trusted” approaches called for by respondents and how the work of the National Rural Mental Health Forum can support this inclusive shift at national and regional levels. This is particularly the case in Local Authority areas with high levels of ruralality.
There is also a need to continue feeding evidence from the rural survey into the National Rural Mental Health Forum and the aforementioned Mental Health Strategy, as well as the National Dementia Strategy (released June 2017), and forthcoming strategies on Suicide and Self-Harm and Social Isolation. The new survey evidence is also relevant to other policy areas such as: Community Empowerment (Scotland) Act 2015 (e.g. through Community Planning Partnerships and their Local Outcome Improvement Plans); the 2016/17 Enterprise and Skills Review; the new Islands (Scotland) Bill; and the Rural Economy and Connectivity portfolio of the Scottish Government.
Finally, this evidence is critical to the elements of the new Mental Health Strategy concerning rural areas because is the first national strategy in health and social care since its integration. This provides significant opportunities for Local Authorities, especially those with significant rural areas, to develop their own approaches and forge new partnerships (with e.g. the National Rural Mental Health Forum and third sector organisations such as SiMS), as well as to work across service boundaries to meet the needs of local populations.
The ultimate aim of this new rural evidence is to improve people’s mental wellbeing. Although the numbers of these rural voices will always remain small – due to being a part of only one fifth of Scotland’s population spread over 98% of its land mass – they nonetheless provide a compelling and authentic evidence base from which to build learning and tailored support.