House of Commons

Environment, Food and Rural Affairs Committee

Rural Mental Health

Fourth Report of Session 2022–23

Report, together with formal minutes relating to the report

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The Environment, Food and Rural Affairs Committee

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> **We understand that some of the issues raised in this report, particularly in Chapter 3, are sensitive and may be upsetting**. The following organisations may be able to offer support or further information:
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> • **Samaritans** — If you need emotional support, Samaritans can be contacted on 116 123 or by emailing jo@samaritans.org. Whatever you're going through, you can call them free any time, from any phone.
>
> • **Mind** — for information, advice, and support for anyone experiencing a mental health problem, Mind can be contacted on 0300 123 3393.

Summary

The available picture of rural mental health across England is complicated and incomplete due to gaps in health data, the suppression of demand by over-centralised services, and the under-reporting of rural deprivation which is inextricably linked to poor mental well-being. While our evidence did not point to a mental health crisis in rural England or the agricultural community, there are several areas of considerable concern—as well as sufficient doubt over the efficacy and granularity of the available data—to make urgent and meaningful Government action on rural mental health essential.

Our evidence highlighted a very consistent set of concerns, risks and exacerbating challenges to rural mental health in England—often with reference to the on-going impacts of Covid, Brexit, the economic ramifications of Russia's invasion of Ukraine, labour shortages, retailer power, shock events, uncertainty over future finances and business succession plans, isolation, trade liberalisation and the cost of living.

While access to nature and the countryside is consistently identified as beneficial for people's mental health in general and often prescribed through 'green social prescribing', our evidence is clear that the isolation inherent in rural living represents a significant challenge to the mental health of adults, children, and young people living in rural areas. It also demonstrates that there are additional and unquantifiable negative pressures on mental well-being within rural communities and amongst farmers, farm workers and veterinary surgeons.

Our inquiry's key findings and recommendations are:

- Rural communities' needs are not fully reflected in mental health policy and services and national NHS planning. The Department for Environment, Food and Rural Affairs and (DEFRA) and the Department of Health and Social Care (DHSC) should establish a new joint rural mental health policy and delivery team to: lead and improve on current "rural proofing" of health policy; and work with NHS England (NHSE) to set targets to measure and improve outcomes for rural mental health services and support rural health providers. In the longer term, a national working group is urgently required to move the approach to policy and planning in this sphere from retrospective 'proofing' to fundamental redesign. This joint DEFRA/DHSC rural mental health team should consider how best to prepare and make effective and integrated interventions with (i) the Department of Transport, and (ii) the new Department of Science, Innovation and Technology, in respect of achieving new levels of accessibility to rural mental health services from new joined-up working, starting with the emerging rural transport strategy and Project Gigabit for rural broadband.

- The Government's announcement of a new approach to suicide prevention—refreshing the 2012 national strategy and reporting against the 2019 cross-government workplan—provides a welcome opportunity to include a focus on agricultural and related veterinary sector workers amongst vulnerable or high-risk groups. When the national strategy is revised DEFRA must advocate

effectively for attention and resources for rural and agricultural mental health priorities; and establish a mechanism—perhaps under the national working group we recommend above—to identify the immediate concerns and actions in relation to these groups. To enable resources to be allocated where they are needed, the Government should confirm and ringfence additional funding, beyond 2023/24, for local suicide prevention to allow local authorities to contribute effectively to delivery of the national strategy.

- NHS mental health services are often not fairly accessible for rural communities, with services largely centred in towns and cities creating barriers to access, compounded by the limitations and weaknesses of rural public transport and digital connectivity. By August 2023, the new joint policy and delivery team we recommend should launch a consultation on how effective the integrated care systems (ICSs) have been at providing rural communities with access to mental health services.[1] By the end of March 2024, proposals should be published for how the new statutory ICS boards and partnerships must address shortcomings, focusing in the first instance on better outcomes and reduced inequalities.

- Far too much avoidable demand ends up at the door of Child and Adolescent Mental Health Services (CAMHS) in rural areas because of a fundamental lack of social infrastructure and youth services. DHSC, NHSE and DEFRA must consult on how to relieve this pressure by accelerating the expansion of preventative mental health support for children and young people by prioritising the roll-out of Mental Health Support Teams to cover 100% of schools and colleges in rural areas by 2026/27; and commit to establish and fund "Early Support Hubs" for children's mental health' in rural areas by 2024/25.

- DHSC and DEFRA must identify supporting and improving the mental health and well-being of those within farming and the agricultural veterinary sectors as high priorities and by September 2023, develop a work programme with NHSE, local public health and occupational charities to identify how to improve mental health outcomes for these occupational groups. Health Education England should work with charities to develop a training programme for rural NHS providers and staff, to be launched by Autumn 2023, to improve mental health care for these occupational groups.

- We recommend that DEFRA and the Department for Levelling Up, Housing and Communities set out a timeline and process by which to review and revise the Index of Multiple Deprivation with the aim of more accurately capturing rural deprivation. The Government should commit to reaching a position by the end of this year, 2023, whereby it can commence a consultation on draft changes to the Index and guidance for decision-makers, and how the Index should be used to support funding decisions.

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1   ICSs have been responsible since July 2022 for planning health and care in England to meet local population needs.

- By December 2023, the Government should fund and roll-out mental health first aid training aimed at creating a critical mass of front-line personnel dealing with farmers and those working and living in rural industries and areas—i.e. in auction marts, agricultural organisations and charities and educational settings—who are able to identify and respond to the need to signpost sources of mental health support.

- Government schemes, associated bureaucracy, and regulatory requirements appeared to be key sources of stress for the farming community. DEFRA has tried to mitigate the burdens of dealing with new agricultural programmes through its Farm Resilience Fund, it is unclear if it is reaching people in most need; if mental health is integrated enough with business resilience; or if it makes best use of established and trusted support groups. The Fund's next round must prioritise mental health support to the farming community alongside business resilience.

- The Government needs to address some of the challenges of rural daily life which can have a significant impact on mental wellbeing. As indicated above, rural transport is a key issue entwined with mental health in terms of both prevention (mitigating isolation and loneliness) and treatment (access to and by services). The Government is currently considering responses to a call for evidence on a future rural transport strategy. The Department for Transport must work with Defra, the DHSC, and NHSE to ensure the prioritisation of access to health services can be maximised to provide rural communities with services and customer experience, whose efficacy is comparable to those within urban areas. The DCMS should be included in this strategic overhaul to ensure the integration of digital connectivity into this picture but without allowing it to be treated, inappropriately, as a panacea, proxy or alternative to face-to-face consultation with a clinician.

- The Government's flagship levelling up agenda includes over-arching reference to the 'rural proofing' of policy that we mention above, and states that: "… government departments are working to support levelling up in rural areas, through targeted approaches where needed, and how we are strengthening the rural economy, developing rural infrastructure, delivering rural services and managing the natural environment." The fundamental need to provide equitable access to effective services for mental health and well-being must be part of this picture. As a start, the Government should consider bringing forward amendments to the Levelling-up and Regeneration Bill, in the House of Lords, to include a mission on young people's mental health and wellbeing and youth services. The DCMS and DEFRA should also issue a call for evidence to assess current and planned new rural youth services against need, and by the end of this year, 2023, develop proposals to fund and make up for any shortfall for the next five and ten years.

1   Introduction

The inquiry

1.   A key priority for the Government and National Health Service (NHS) in recent years has been to increase people's access to mental health support and improve the quality of mental health services, including by the allocation of more funding.[2] Concerns about the availability and take up of mental health services in rural communities and amongst agricultural and veterinary workers have been raised frequently in our work.[3] We therefore launched this inquiry in November 2021, calling for written evidence on:

- the specific mental health challenges faced by those living and working in rural communities

- the adequacy and effectiveness of mental health and suicide prevention service provision for those working in agriculture and those living in rural areas

- the causes of higher-than-average rates of suicide amongst those working in agriculture; the extent to which associated professions such as vets are affected; and the effectiveness of suicide prevention services offered to these groups

- the sufficiency of mental health support made available to rural communities following "shocks" such as flooding or mass animal culls

- whether the Government's recent investment in mental health services adequately provides for rural mental health, and

- the level of joined up working between key actors, such as Government departments, DEFRA and DHSC, NHS and public health bodies, and local government, in their approach to improving the quality of, and access to, mental health services in rural and agricultural communities.[4]

2.   We have published nearly 50 written submissions and held five oral evidence sessions with 11 panels of witnesses.[5] We thank everyone who contributed evidence which came from individuals, charities, researchers, businesses, local government, agricultural professions, health service providers and planners, NHSE and the Government.

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2   NHS England, *The NHS Long Term Plan* (January 2019) pp7–8 (with funding for NHS mental health services increasing faster than overall NHS funding and funding for children and young persons' mental health services growing faster than the mental health total, pp50 and 68)

3   See, Environment, Food and Rural Affairs Committee, *Flooding* (February 2021); *Environmental Land Management and the agricultural transition* (October 2021); *Labour shortages in the food and farming sector* (March 2022); Action with Communities in Rural England (ACRE), *Health and care in rural areas* (January 2019) p10; Centre for Mental Health blog by Melanie Costas and Olivia Smith *Unseen and unheard: Tackling inequality in rural mental health* (December 2020) [accessed 12 December 2020]; Environment, Food and Rural Affairs Committee, *Flooding* (February 2021); Royal Agricultural Benevolent Institution's *The Big Farming Survey* (October 2021); Institute for Employment Studies, *The 2019 survey of the veterinary profession - A report for the Royal College of Veterinary Surgeons* (February 2020) p16; *The 2019 Survey of the Veterinary Nursing Profession - A report for the Royal College of Veterinary Surgeons* (February 2020) p10; and Office for National Statistics, *Suicide by occupation, England: 2011 to 2015* (17 March 2017).

4   Environment Food and Rural Affairs Committee, *MPs study rural mental health – a sometimes hidden topic* (November 2021)

5   Environment Food and Rural Affairs Committee, *Rural mental health*

3.   Members of the Committee also visited the volunteer group, Farmerados, in Taunton, Somerset, to talk to volunteers and farms about the mental health challenges facing the farming community. We are grateful for everyone who took the time to speak to us. We were also very grateful to the Mancroft Advice Project for preparing to host us in Norfolk to hear views of young people about mental health in rural areas and were disappointed that in the end this did not take place. We also wish to acknowledge the contribution of Mubeen Bhutta, Head of Policy, Public Affairs and Campaigns at Samaritans, who acted as a Special Adviser during the writing of this report.

The report

4.   In this report, Chapter 2 first sets the terms of debate and then explores what the available data and other information can reveal about the incidence, prevalence and risks of poor mental health in England's rural communities, including a focus on farming and agriculture. Chapter 3 then examines the rates and risks of suicide in rural areas, particularly, in relation to agricultural and veterinary workers, and looks at relevant past performance and future plans for suicide prevention. Chapter 4 looks at the policies, plans and delivery of NHS, local and national government mental health and related services (alongside contributions from other bodies). Chapter 5 explores how DEFRA and the Government as a whole is taking account of rural mental health issues in wider policy and regulatory matters. Chapter 6 looks at the potential impacts of the Government's "levelling up" agenda on rural areas.

2   State of mental health in rural England

What we mean by *rural* and by *mental health*

Rural areas

5.   In line with DEFRA's definition, in this report we consider "rural" areas to be those settlements of less than 10,000 residents. Figure 1 shows England's rural and urban areas local authorities based on the 2011 Census. In 2020, England had a population of around 56.6 million people of whom 9.7 million (17%) lived in an area defined as rural.[6]

Figure 1: Rural-Urban Classification for Local Authorities in England, 2011
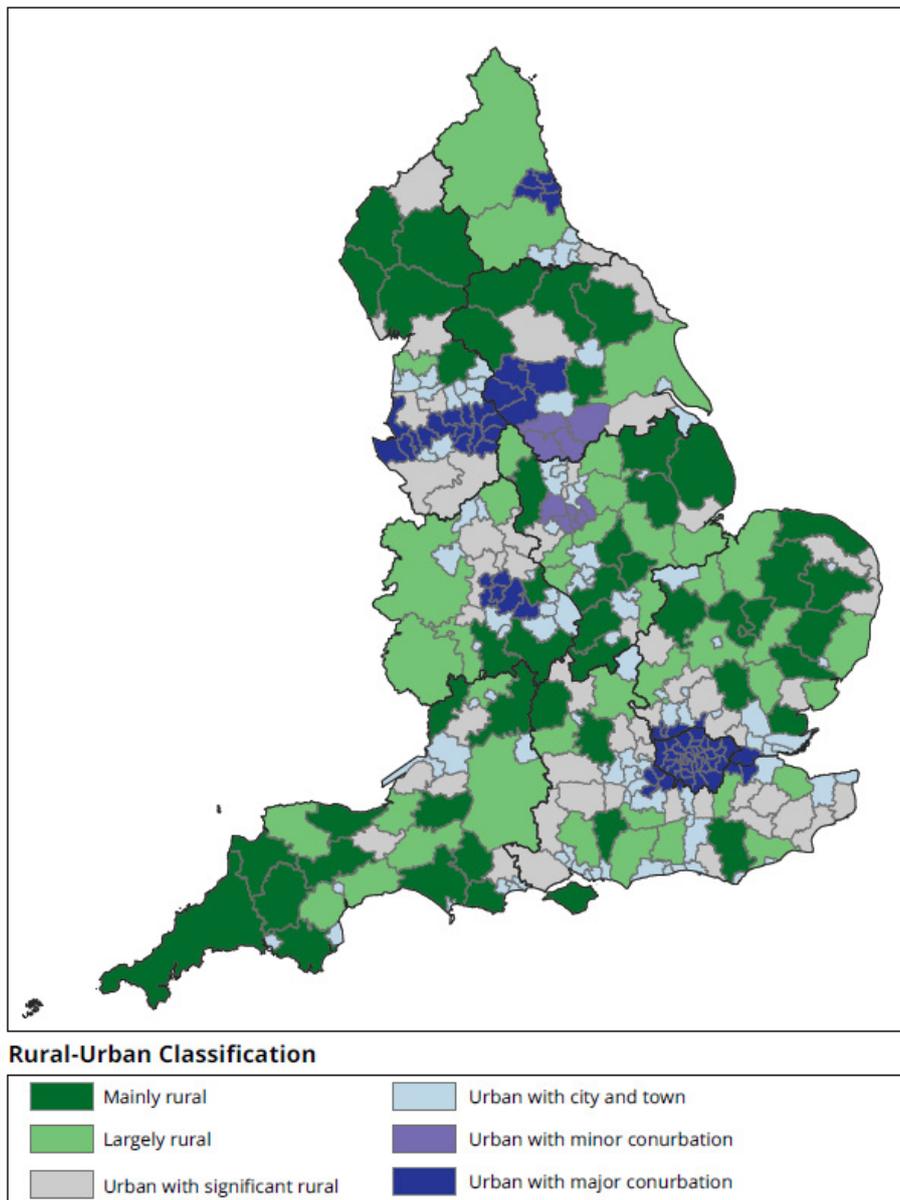
Rural-Urban Classification

■ Mainly rural	■ Urban with city and town
■ Largely rural	■ Urban with minor conurbation
■ Urban with significant rural	■ Urban with major conurbation

6   Department for Environment, Food and Rural Affairs, *Statistical Digest of Rural England - July 2022 Edition* (August 2022) pp6–11

6.   The available data indicate that such areas tend to have an older age profile and a less ethnically diverse population. In 2022 rural areas had a higher proportion of people aged 65 and over (25.4%) compared to the urban population (17.1%), and an average age of just over 45 years old (nearly 6 years older than the average in urban areas) with people of white ethnicity accounting for 96.8% of the rural population compared to 81.7% in urban areas.[7]

Mental health

7.   In its 2022, post-Covid review of the state of global mental health,[8] the World Health Organisation (WHO) defined mental health as: "… a lot more than the absence of illness: it is an intrinsic part of our individual and collective health and well-being" enabling "people to cope with the stresses of life, to realize their abilities, to learn well and work well, and to contribute to their communities."[9] The WHO describes the impact of mental health impairment as disturbance to thoughts and feelings, changes in behaviours, compromise of physical health and disruption of relationships, education or livelihoods.[10]

8.   The experience of mental ill health can vary hugely between individuals, including those with the same diagnosis, and over time. The context in which people deal with various conditions—for example the presence or absence of familial or social support, or a person's financial situation, and many other factors—will also have a bearing on individual experience. The relationship between symptom, experience and outcome in mental health can be multidirectional, and can occur with positive and negative feedback loops. Social isolation, for example, may occur as a result of poor mental health, or it may be a contributing factor.[11]

Well-being and mental well-being

9.   Well-being has many dimensions. There is also a two-way relationship between well-being and health/mental health, with the latter being one of the top factors identified by people as influencing their well-being. Conversely, levels of well-being will influence people's health and mental health.[12]

10.   The Government has traditionally regarded overall well-being as "a shared government objective" around which to engage to deliver health and social objectives.[13] In its recent *Mental health and wellbeing plan: discussion paper*, the Government defined *mental health* as "a state of wellbeing in which an individual realises his or her own abilities, can cope

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7   Department for Environment, Food and Rural Affairs, *Statistical Digest of Rural England - July 2022 Edition* (August 2022) pp11, 18–19.

8   World Health Organization, *World mental health report: Transforming mental health for all* (June 2022).

9   World Health Organization, *World mental health report: Transforming mental health for all* (June 2022) pp vi and 8

10   World Health Organization, *World mental health report: Transforming mental health for all* (June 2022) p11

11   European Centre for Environment and Human Health WHO Collaborating Centre Natural Environments and Health - University of Exeter Medical School, *A Handbook for Nature on Prescription to Promote Mental Health*, (January 2021) p2

12   World Health Organization, *World mental health report: Transforming mental health for all* (June 2022) p11

13   Department of Health, *The relationship between well-being and health*, (February 2014) p2

with the normal stresses of life, can work productively and is able to contribute to their community"; and *mental wellbeing* as "about thoughts, feelings, and how people cope with the ups and downs of everyday life".[14]

Current state of rural mental health in England

Data quality

11.   The state of mental health across England's rural communities is difficult to measure with confidence and authority. As Gillian Keegan MP, then Care and Mental Health Minister at DHSC, herself acknowledged, the existing mental health surveys for adults and for children: "… are about the general population and they do not look at prevalence in different types of rural or urban communities."[15] Claire Murdoch, National Director for Mental Health at NHS England, was more positive when asked whether the NHS had an accurate picture of the mental health needs of people in rural areas:

> When I began in the role a few years ago we had very little information but we have seen a sea change in recent years such that we can publish a range of data and we do that quarterly, right down to the region and places below the regional level. […] we can cut that data now with much more granular detail in local areas but I would always say that we have further to go. I do not think we can be complacent for one moment when it comes to mental health.[16]

Minister Keegan commented that:

> On information about access to mental health services we have got the new integrated care system set up a week last Friday [1 July 2022] […] they are best placed to understand local population."[17]

12.   Successive reports and initiative over the years, such as from the Local Government Association (LGA) and Public Health England (PHE) in 2017,[18] and the All-Party Parliamentary Group on Rural Health and Care in 2022[19], have also highlighted the challenge of a lack of health, mental health and well-being data differentiated between urban and rural areas. There have also been consistent criticisms of data that is collected, for instance by local health and well-being boards[20], for being at too high a level to identify the small and dispersed populations' needs; and this was emphasised throughout our evidence, for example by Dr Tim Sanders, giving evidence on behalf of the Royal College of General Practitioners (RCGP), who told us:

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14   Department of Health and Social Care, *Mental health and wellbeing plan: discussion paper* 'Table of definitions' [accessed 17 October 2022]

15   Q294 [Gillian Keegan MP]

16   Q263 [Clare Murdoch]

17   Q294 [Gillian Keegan MP]

18   Public Health England and Local Government Association, *Health and wellbeing in rural areas* (March 2017) paras 10–11

19   All-Party Parliamentary Group on Rural Health and Care and the National Centre for Rural Health and Care, *APPG Rural Health and Care* (February 2022)

20   Health and well-being boards were established under *The Health and Social Care Act 2012*. They are a formal committee of the local authority responsible for promoting greater integration and partnership between the NHS, public health and local government. They have a statutory duty, with Clinical Commissioning Groups to produce a Joint Strategic Needs Assessment and a Joint Health and Wellbeing Strategy for their local population.

I am not sure that there is a very accurate picture of rural mental health needs that comes across. I understand that data are gathered by public health and fed into local health and wellbeing boards, but I think that is on too large a level to pick up the unique needs of the small rural populations that we serve. […] We hope and anticipate that because of this, better data on our rural populations will become available, but only time will tell if that takes place. There are major challenges in gathering data that is meaningful, given the wide variety of the populations that we look after.[21]

13.   A related issue which affects an understanding of the true picture of rural mental health is the under-reporting of deprivation. Poverty is closely linked to poor mental health particularly when experienced in early years, with a 2020 Centre for Mental Health (CfMH) report on *Children's mental health in isolated areas* concluding that: "by the age of 11, children from the poorest 20% of households are four times as likely to have serious mental health difficulties than those from the wealthiest 20%".[22] Our evidence also highlighted this link, for example, by the rural community council, Rural Action Derbyshire[23] who distribute funding on the basis of: "… poor to severe mental health conditions arising from financial difficulties and untreated conditions."[24] However, deprivation itself is not well recorded in a rural context:

- CfMH CEO, Sarah Hughes, told us that national measures of relative deprivation like the Index of Multiple Deprivation (IMD) published by the Department for Levelling Up, Housing and Communities "just do not dig deeply enough".[25]

- The IMD can overlook rural deprivation which tends to occur in very small clusters and individual scattered households whilst capturing concentrated urban deprivation, as previously acknowledged by PHE, the LGA and DEFRA,[26] including in evidence to us from Minister Lord Benyon, who said that for people in an assumed "affluent area" whose need does not register on the IMD, "life can be much tougher than for somebody who is living in an area where it is more visible."[27]

14.   It is relevant and worth drawing attention to material, cited particularly by the CfMH, that this patchwork of affluence and deprivation in rural areas does not just vex statistical methodologies but also has material impacts. The Centre pointed to evidence from England and Northern Ireland that the close proximity of deprived and affluent areas in a rural context is felt more acutely and can lead to social exclusion, marginalisation, and feelings of detachment, alienation and powerlessness, especially amongst young people.[28]

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21   Q235 [Dr Tim Sanders]

22   Centre for Mental Health, *The space between us: Children's mental health and wellbeing in isolated areas* (August 2020) p8.

23   Rural Action Derbyshire [MH0006] para 2; Department for Environment, Food and Rural Affairs, *Statistical Digest of Rural England - July 2022 Edition* (August 2022) p6 p135

24   Rural Action Derbyshire [MH0006] para 4. The Fund is supported by the Princes Countryside Trust and Derbyshire County Council

25   Qq5–75 [Sarah Hughes]

26   Public Health England and Local Government Association, *Health and wellbeing in rural areas* (March 2017) paras 10–11; Department for Environment, Food and Rural Affairs, *Statistical Digest of Rural England - July 2022 Edition* (August 2022) p6 p135

27   Q311 [Lord Benyon]

28   Centre for Mental Health [MH0037] paras 7–8

Mental health challenges in England

15.   The absence of data on prevalence of mental health conditions broken down between urban and rural areas[29], much of our evidence addresses likely risk and aggravation factors around mental ill health within rural and agricultural communities. For the purposes of comparison, such factors of common mental health conditions, and at-risk groups in England as a whole, feature:

- social factors, including: poverty, housing, social isolation, and social and familial relationships are associated with mental health problems

- other health factors as people with long-term physical health conditions are two to three times more likely to experience mental health problems than the general population, and

- while anyone can be affected by mental health problems, some groups experience a higher prevalence: Black women, adults under the age of 60 who live alone, women who live in large households, adults not in employment, those in receipt of benefits, and those who smoke cigarettes (i.e. reflecting the association of increased social disadvantage and poverty with higher risk of CMD).[30]

Impact of the Covid pandemic

16.   There have been multiple surveys and studies of the mental health and well-being impacts of the Covid pandemic, many corralled by the led by the Office of Health Improvement and Disparities (some aiming for real-time surveillance to support decision-making).[31] These studies indicated fluctuations in mental health which broadly matched the pattern of Covid prevalence and the requirements to isolate and lock down. The tracking of reported psychological distress, stress, anxiety, depressive symptoms, loneliness and sleeplessness showed many similar patterns, with clinically significant problems increasing towards April 2020, falling back by September 2020, increasing again in January 2021 and falling in late March 2021—however periods of recovery in summer 2020 and autumn 2021 were either not observed or did not return to pre-pandemic levels in all studies.[32] The legacies and implications of Covid in rural areas were raised throughout the evidence submitted to us: both as an aggravating factor in relation to the stresses on rural mental health and also as a cause, in its own right, of specific new anxieties and pressures.

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29   For overall statistics see: NHS Digital, *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 -* Table 2.4 CMD in past week, by age and sex, all adults (16–75+) (September 2016). Note: A respondent may report more than one CMD.

30   NHS Digital, *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 -* Table 2.4 CMD in past week, by age and sex, all adults (16–75+) (September 2016), page 61

31   Office for Health Improvement and Disparities, *COVID-19 mental health and wellbeing surveillance report: Chapter 1 About COVID-19 mental health and wellbeing surveillance*, (April 2022) [accessed 22 April 2023]

32   Office for Health Improvement and Disparities, *COVID-19 mental health and wellbeing surveillance report: Chapter 1 About COVID-19 mental health and wellbeing surveillance*, (April 2022) [accessed 22 April 2023]

Indicative evidence on rural health

The farming community

17.   In 2020, there were about 472,000 people working in UK farming.[33] Survey research (cited by many of our witnesses, including the Care and Mental Health Minister Gillian Keegan MP[34]) that might also stand as proxy evidence for the state of rural mental health was *The Big Farming Survey* undertaken for the Royal Agricultural Benevolent Institution (RABI) in 2020/21. This was a survey of 15,000 farmers, farm workers, contractors, and their households, looking at the health and wellbeing of the farming community in England and Wales in the 2020s.[35] Headline findings from RABI's questions to these groups were:

- results revealed for the first time a clear relationship between levels of mental health and business health[36]

- the farming community has a lower level of average mental well-being than the UK population as a whole[37], see Figure 2 below (although estimates for the wider population predate the Covid-19 pandemic)

- 36% of respondents had mental wellbeing scores that are sufficiently low to cause concern, 21% were probably depressed and a further 15% were possibly depressed (according to NHS thresholds)[38]

- 47% of respondents were experiencing some form of anxiety, of which substantial minorities were reporting either moderate (12%) or severe levels of anxiety (6%),[39] and

- 19% knew someone who had attempted to take their own life.[40]

Other key findings were:

- 43% of women in the farming community aged 25 -44 compared to 33% of men were possibly or probably depressed, and 58% of women compared to 44% of men were suffering from mild, moderate or severe anxiety.[41] Key reasons may be persistent traditional gender roles in family farming, with women often having to "juggle multiple home, childcare, and business related tasks, which can be stressful and isolating, particularly if their partner works long hours on the farm."[42]

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33   Department for Environment, Food and Rural Affairs, *Farming statistics - final crop areas, yields, livestock populations and agricultural workforce at 1 June 2020 United Kingdom* (December 2020) p21. This comprised of 171,500 employees, salaried managers or casual workers and 147,000 full-time and 153,500 part-time farmers, business partners, directors or spouses.

34   Q294 [Gillian Keegan MP]

35   Royal Agricultural Benevolent Institution, *The Big Farming Survey* (October 2021) pp4–6 and 14

36   Royal Agricultural Benevolent Institution, *The Big Farming Survey* (October 2021) p9

37   Royal Agricultural Benevolent Institution, *The Big Farming Survey* (October 2021) p6

38   Royal Agricultural Benevolent Institution, *The Big Farming Survey* (October 2021) p4

39   Royal Agricultural Benevolent Institution, *The Big Farming Survey* (October 2021), using General Anxiety Disorder 7-scale, p4

40   Royal Agricultural Benevolent Institution, *The Big Farming Survey* (October 2021), p11

41   Royal Agricultural Benevolent Institution, *The Big Farming Survey* (October 2021) pp4–6 and 14

42   Centre for Rural Policy Research (CRPR) University of Exeter (MH0029) para 20

- Also that there appears to be a relationship between people's mental health and the sector of farming they are involved in. Livestock-farming were most likely to report poor mental wellbeing, with 47% from specialist pig, 39% from Less Favoured Areas grazing livestock and 39% from dairy farms, reporting they were possibly or probably depressed.[43] This may be due to the physical demands of livestock farming which can have a 'knock-on' effect on farmers' physical health, it being more financially challenging than arable farming, with greater reliance on farm subsidies and low profit margins.[44]

18.   The RABI survey set out a number of causes of stress amongst farmers and farming people, ranked by the percentage of survey respondents who identified them, see Figure 3 below.

Figure 2: Average mental health in the UK population and farming community
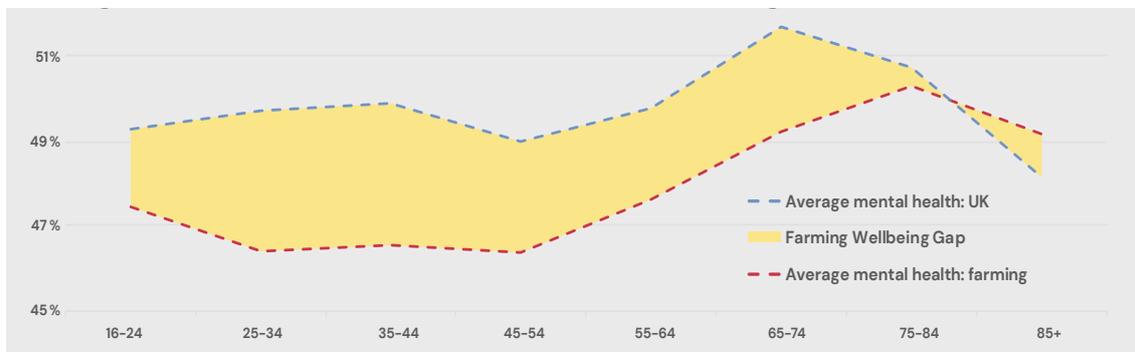
Source: Royal Agricultural Benevolent Institution, *The Big Farming Survey* (October 2021) p6

Figure 3: Causes of stress amongst farming people (%)

Source: Royal Agricultural Benevolent Institution, *The Big Farming Survey* (October 2021) p8

19.   Top causes of stress for farmers included some where the Department had significant opportunities to make a difference: regulation, compliance and inspection; loss of subsidies/future trade deals; the future of farming. This was supported by other evidence in terms of both the burden of bureaucracy and inspections but also stress from fear of being unfairly penalised for honest mistakes or small lapses with regard to obligations resulting in delays in payments or lost contracts.[45] The Bovine Tuberculosis Partnership

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43   Royal Agricultural Benevolent Institution, *The Big Farming Survey* (October 2021) p5; Centre for Rural Policy Research (CRPR) University of Exeter (MH0029) para 9

44   Q9 [Dr Wheeler]

45   Centre for Rural Policy Research (CRPR) University of Exeter (MH0029) para 12; Q175 [Edward Richardson] and see *Red Tractor assurance scheme* [accessed 14 December 2022]

for England (BTPE) provided evidence on the impact of the management of animal disease outbreaks on farmers' mental health (as opposed to simply the outcome for the herd) and the importance of effective communications and appropriate participation in decision-making.[46]

20. Another example was the Government's new Environmental Land Management (ELM) programme which aims to accomplish the post-Brexit shift of agricultural policy and financial subsidies towards the payment of public money for delivering environmental public goods. Although we note the welcome given to announcements earlier this year,[47] there was a great deal of uncertainty about how the scheme would work and what the payments would be,[48] giving rise to a perception that farmers would be better off planting trees than producing food.[49] Melinda Raker, of the farming charity YANA, told us that the Government does not seem to understand that its decisions impact industry and individuals almost straightaway, which means farmers need a lot of resilience to deal with changes in policy.[50]

21. Financial pressure is an acknowledged challenge to anyone's mental health and well-being but we were struck by some of the anecdotal evidence we heard of low prices and high debt.[51] For example, there was the price of wheat only increasing three times in the last 42 years and just twice for milk since 1990.[52] Whilst Edward Richardson told us some farms he has visited have "huge amounts of debt—an incredible amount of creditors." He said:

> I have been to farms where they would refuse to open the post. One farmer we went to had not opened the post for four years […] it took us four days to open it: Christmas cards, letters, cheques. He did not want to answer the telephone because he knew [someone] would be ringing up because he had not been paid. That debt issue is hundreds of thousands.[53]

22. Since taking evidence, Russia's illegal invasion of Ukraine has resulted in unprecedented price volatility for both agricultural inputs, such as fertiliser and fuel, but also the outputs—commodities such as oilseeds and grain. This has put considerable pressure on farmers, in particular livestock farmers who buy in feed and whose output prices did not initially keep pace with this.[54]

23. The issue of not feeling valued by the public was highlighted many times in our inquiry, reflecting the farming community's perception that wider society is generally negative towards it, appreciating neither food production nor land management.[55] Stephen Dodsworth of Darlington Farmers Auction Mart, told us livestock farmers "are

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46   Bovine Tuberculosis Partnership for England [MH0030] paras 7–10

47   National Farmers' Union, *ELMs – Defra announces long-awaited detail on actions for funding*, 26 January 2023, referring to Department for Environment, Food and Rural Affairs, *Environmental Land Management (ELM) update: how government will pay for land-based environment and climate goods and services*, (February 2023)

48   Environment, Food and Rural Affairs Committee, *Environmental Land Management and the agricultural transition,* (October 2021); Rural Action Derbyshire [MH0006] para 4; National Farmers Union (MH0028) para 7

49   Qq172–3 [Trudy Herniman]; Q176 [Stephen Dodsworth]

50   Q174 [Melinda Raker] and Q175 [Edward Richardson]

51   Q175 [Melinda Raker; Edward Richardson]

52   Q175 [Edward Richardson]

53   Q175 [Edward Richardson]

54   House of Commons Library, *The effect of the war in Ukraine on UK farming and food production* (December 2022)

55   Q92 [Dr McCann]; Qq171 and 76 [Stephen Dodsworth]

persecuted by the media" and fear picking up a newspaper or turning on the television, and he cited "an old adage that farming is working 100 hours a week to feed people convinced you are trying to kill them."[56] A further challenge is that many of those hours are spent lone working with little if any opportunity for time off.[57]

Veterinary workers

24.   We considered the specific issue of veterinary workers given the shared issues, as well as the mutually supportive nature, of farming and rural veterinary practice, in the mental health sphere. Data published on behalf of the regulatory body the Royal College of Veterinary Surgeons (RCVS), show that in 2019:

- There were about 25,800 UK-practising veterinary surgeons (63% female and 37% male) and just over 17,000 veterinary nurses (97% female and 3% male)[58] and

- the workplaces of veterinary surgeons were situated 39.5% urban, 23.9% rural and with 36.5% covering mixed urban and rural areas (with a broadly similar distribution of veterinary nurses).[59]

25.   The British Veterinary Association reported that a reduction in veterinary practitioners after Brexit had been accompanied by significant increases in demand for services due to various post-Brexit trade requirements and Covid-related increases in pet ownership; all said to make existing difficulties in recruitment and retention more challenging.[60]

26.   Surveys conducted in 2019 of RCVS members repeated previous findings from 2010 and 2014 that veterinary surgeons and nurses both continued to report high levels of stress in their work.[61] A 2018 survey of BVA members found that 77% of vets surveyed had been concerned about a colleague or fellow student's mental health and wellbeing.[62] Published research indicated that major sources of veterinary workplace stress include a high workload and a lack of work-life balance, lone working out-of-hours leading to social isolation, a lack of social support and difficulties or conflict in work relationships, and exposure to animal suffering.[63]

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56   Q170 [Stephen Dodsworth]
57   Q92 [Dr McCann]; Q171 [Stephen Dodsworth]; Q175 [Edward Richardson]; Centre for Rural Policy Research (CRPR) University of Exeter (MH0029) para 22
58   Royal College of Veterinary Surgeons, *RCVS Facts 2019* (August 2022) pp4–8, 11 and 13
59   Institute for Employment Studies, *The 2019 survey of the veterinary profession - A report for the Royal College of Veterinary Surgeons* (February 2020) p56, and *The 2019 Survey of the Veterinary Nursing Profession - A report for the Royal College of Veterinary Surgeons* (February 2020) p43. The surveys state the percentages may add up to only a little over 100%, suggesting that the workplaces of most respondents who regularly work in two or more locations are similar in nature.
60   British Veterinary Association, *UK's veterinary workforce crisis deepens as EU registrant numbers drop by over two-thirds since Brexit* (February 2022)
61   Institute for Employment Studies, *The 2019 survey of the veterinary profession - A report for the Royal College of Veterinary Surgeons* (February 2020) p16, *The 2019 Survey of the Veterinary Nursing Profession - A report for the Royal College of Veterinary Surgeons* (February 2020) p10.
62   British Veterinary Association, *Don't be afraid to reach out to colleagues, say BVA and Vetlife* (May 2018)
63   Royal College of Veterinary Surgeons/ Mind Matters, *A guide to enhancing wellbeing and managing work place stress in the veterinary workplace* [accessed 14 November 2022] pp2–10; A. McKenzie, R. Allister, D. Humphrey, K. Moore, K. Greenberg and N. Greenberg, *An evaluation of a veterinary-specific mental health service*, *Occupational Medicine*, Volume 70, Issue 3 (April 2020), pp 169–175

27.   We identified additional stressors on the mental health of veterinary surgeons and nurses working in rural areas in evidence to the Committee. First was the inability to secure cover for their duties and obligations, despite being mentally or physically unwell, or meriting a holiday (including for the purposes of visiting family not seen for over a year or more).[64] Secondly, we heard about the extreme psychological burdens shouldered and carried by veterinarians working alongside farmers struggling with financial, physical or mental health problems, or family difficulties (and being one of few sources of emotional support).[65] Also, there seemed to be a particular challenge for new veterinary graduates who are starting work in rural communities and encountering these circumstances and demands.[66]

28.   Finally, there was the headline burden and challenge of dealing with animal disease breakouts and, again, working with a potentially devastated farmer or group of farmers in need of support and counselling as much, if not more than, testing and culling services.[67] The BTBP told us that this "social worker" role was precisely what many vets ended up fulfilling, without the safety net or boundaries of relevant training and providing care to the farmer "as much as to their animals" in terms of advice, signposting to services or personal help.[68] The Partnership added that the work of the official TB Advisory Service, through which vets are trained to support people in distress, nevertheless could be "extremely draining" and takes its own toll on veterinarian advisers.[69] BTBP also cited research that showed a vet's negative experiences of TB testing can result in loss of enjoyment of the profession; leaving farm animal practice; moving abroad to where there is no bovine Tuberculosis (bTB) testing, or leaving the profession altogether.[70]

Positive mental health outcomes of rural working

29.   The National Farmers' Union (NFU) highlighted, despite the many challenges cited, the RABI survey itself found optimism about the future of farming in England with 59% of respondents believing that their farming business was viable over the next five years.[71] In addition, more broadly, a relatively positive picture has been painted by some of the research cited by DEFRA:

- people living in predominantly rural areas report slightly higher rates of well-being than those living in mainly urban areas

- more people living in rural than urban areas report they are satisfied with their local areas as a place to live, and

- that rural communities are felt to provide a strong sense of belonging, compared to what people living in urban areas report.[72]

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64   Qq109 and 111 [Dr Allister]; Q110 [James Russell]
65   Q110 [James Russell]; Q218 [Kate Miles]
66   Q109 [Dr Allister]; Q110 [James Russell]
67   Q111 [Dr Allister]; Bovine Tuberculosis Partnership for England [MH0030] paras 7–10.
68   Bovine Tuberculosis Partnership for England [MH0030] paras 13–14
69   Bovine Tuberculosis Partnership for England [MH0030] para 14. The TB Advisory Service is funded by DEFRA to provide "free bespoke, practical, and cost-effective biosecurity advice."
70   Bovine Tuberculosis Partnership for England [MH0030] para 11
71   National Farmers Union (NFU), (MH0028) para 5
72   Department for Environment, Food and Rural Affairs, *Statistical Digest of Rural England - July 2022 Edition* (August 2022) pp177–82, 185–87

30.   In the Government's 2018 strategy for tackling loneliness (the responsibility of the former Department for Digital, Culture, Media and Sport), the then DEFRA Minister for Rural Affairs and Biosecurity, Lord Gardiner, was given prominence stating that: "We know that people living in rural areas can face particular challenges to social connection in terms of transport, services and simply feeling there's 'someone like me' living locally. At the same time, rural areas often have a strong community culture and people living in the countryside are no more likely to report feeling lonely than those in our cities."[73] In addition, a subsequent PHE overview of relevant studies also indicated that older people living in rural areas can have good access to community networks, services, family support and informal care.[74]

31.   While acknowledging substantial issues arising from deprivation, barriers to services and the sparsity of evidence about rural mental health needs, the CfMH cited research which, reflecting Lord Gardiner's relatively sanguine view, showed people living in rural areas reporting strong community relationships, better neighbourhood environments and high levels of well-being and satisfaction.[75]

32.   With respect to children and young people, the CfMH also referred to evidence that:

- young people in rural England received fewer school exclusions and had lower emotional and mental health needs than their urban counterparts (although displaying more 'risky behaviours', including alcohol consumption, smoking and bullying/ being bullied), and

- 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%), concluding that loneliness was not defined by children by space or place, but by a sense of exclusion, disconnection from others, unhappiness with relationships, or experience of punishment.[76]

That said, we return to children and young people's experience later.

Nature and countryside-related contributions to good mental health

33.   A consistent thread through Government strategies and policies on improving mental health has been promoting "green social prescribing" whereby people and groups are supported to use the natural environment to help tackle loneliness and mental ill health and foster community participation and cohesion.[77] The evidence linking exposure to nature and natural environments to improvements in mental health supports nature-

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73   Department for Digital, Culture, Media and Sport, 2018, *A connected society: a strategy for tackling loneliness,* p39. DEFRA's commitments included convening stakeholder roundtables on tackling rural loneliness (a programme interrupted by the Covid pandemic now revived according to the 2022 third annual report)

74   Public Health England, *An evidence summary of health inequalities in older populations in coastal and rural areas Executive summary and main messages* (August 2019) p3

75   Centre for Mental Health [MH0037], paragraphs 4 and 5

76   Centre for Mental Health [MH0037], paras 4–5

77   Department for Environment, Food and Rural Affairs, *Rural Proofing in England 2020 Delivering policy in a rural context* (March 2021) p42–3, *Delivering for Rural England – the second report on rural proofing* (September 2022) p28–9

based offerings as a core referral option in wider "social prescribing". Experience of nature and the countryside has a long history as a therapeutic tool but integration with the formal healthcare system as 'green prescriptions' is relatively new.[78]

34.   However, it seems clear that the benefits of countryside and nature-based interventions are likely still largely founded on their character as a purposeful intervention and group activity. Dr Kreseda Smith, a Rural Criminologist and Lecturer at Harper Adams University, drew our attention to the unlikelihood of people living *in* rural/farming communities finding nature-based prescribing necessarily helpful for their mental health, "as they may perceive that very same countryside as part of the problem".[79] Taking a broader view, the National Rural Mental Health Forum (NRMHF) criticised the "myth of rural life as an idyll" that not only hiked rural house prices but has created more demand for scant health and mental health services from a disappointed group of aging 'migrants'.[80] A more direct perverse impact was suggested by some of our evidence, in the potential for the general promotion of mental health benefits from countryside and nature to create further pressure on one of the stresses on farmers listed below, conflict over public access to land.[81]

Risks, stresses and challenges to rural mental health

35.   The majority of our evidence highlighted a very consistent set of concerns, risks and exacerbating challenges to rural mental health in England—often with reference to the on-going impacts of Covid, Brexit and the economic ramifications Russia's of invasion of Ukraine—and this included DEFRA's response to our specific questions and further CfMH evidence describing the very serious obstacles and barriers in rural areas to access to, and provision of, services aimed at preventing or treating mental ill health, especially in the case of children and young people.[82]

36.   The Department itself highlighted a number of factors posing a challenge to the maintenance of good mental health in a rural context. These include rural isolation and lack of accessible mental health services compounded by limited public transport in rural areas, poor accessibility to wider, anecdotal reports of mental health and wellbeing challenges faced by those in sectors affected by labour shortages, and workers in animal culling potentially experiencing work-related stresses.[83]

37.   Concerns, risks and exacerbating challenges to the promotion of good mental health in rural areas appear to fall into the following categories and elements:

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78   European Centre for Environment and Human Health WHO Collaborating Centre Natural Environments and Health - University of Exeter Medical School, *A Handbook for Nature on Prescription to Promote Mental Health*, (January 2021) p10

79   Dr Kreseda Smith, Harper Adams University [MH0005], paragraph 11

80   National Rural Mental Health Forum (MH0022) para 13. The NRMHF was set up by Support in Mind Scotland in 2017 and is a partner in Mental Health UK which brings together charities working across all four UK-nations. The NRMHF has around 220 membership organisations, many covering the UK which include the voluntary, public and private sectors. It is also an action of the Scottish Government's Mental Health Strategy.

81   Centre for Rural Policy Research (CRPR) University of Exeter (MH0029) para 11

82   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) paras 8–11; Centre for Mental Health [MH0037], paras 9–20

83   Department for Environment Food & Rural Affairs (MH0036) paras 1–4

Overall

- *Social and physical isolation* arising from poor transport and weak digital connectivity, all worsened by the Covid legacy, was a key issue raised throughout our evidence as damaging both to the day-to-day maintenance of mental health through social contact and also the ability to seek out, gain access to, *and return home from*, mental health services when needed,[84] and

- *Rural reticence* in the form of a strong unwillingness amongst people in rural communities to share problems informally, let alone seek professional help, due to the perceived stigma or "traditional rural masculinity" (probably giving rise to 81% of farmers under 40 reporting that poor mental health was their biggest *hidden* problem); and where any innate reluctance to seek help will inevitably make any sort of practical barriers or obstacles disproportionately impactful.[85]

Invisibility and visibility

- *Perceived absence of services* occurring when poor transport connections are exacerbated by other factors to make services more or less invisible to potential clients in need, delaying contact until a crisis arises,[86] and

- *Lack of confidentiality or privacy* where the act of seeking help can be all too visible in a close-knit community where the condition or events driving the need for help may also be, or feel, very obvious and impossible to keep private.[87]

Hardship and life change

- *Impact of poverty or fear of it,* whether from loss of livelihood, food or fuel prices, changes to benefits or physical health issue, and

- *Common challenges,* including bereavement, dependency or dependants' issues (care or carer needs), housing or homelessness, historical child abuse, neighbour disputes, or any number of chronic health conditions.[88]

Agriculture and farming

- burdens of expectation relating to the protection, development, and at least preservation, of farm and land legacy and pressures to invest, whether in automation or new accreditation

- challenges of post-Brexit change and uncertainty in the face of emerging new arrangements

- vulnerability to shocks, such as disease and forced culls, flooding, and other unexpected weather, man-made blights such as rural crime or pollution incidents; connected to this, chronic intermittent stress caused by necessary bTB testing

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84   Q52 and Q61 [Barbara Piranty]; Q57 [Melanie Costas]; Q76 [Dan Mobbs]

85   The National Rural Mental Health Forum [MH0022] paras 10 and 13; Dr Kreseda Smith, Harper Adams University [MH0005], paras 2–3; Centre for Rural Policy Research (CRPR) University of Exeter (MH0029) para 23

86   Q52 [Melanie Costas]

87   The National Rural Mental Health Forum [MH0022] para 10

88   Q130 [Carol Stockman]; Rural Action Derbyshire [MH0006] paras 2–4

- negative media coverage and public perception of farming, linked to environmental and sustainability issues, costs and prices and also public access controversy (e.g. damage and conflict with walkers and dogs), and

- inability to take time-off, including for pain or other manifestations of poor health (including mental ill health).[89]

Children and young people in rural communities

38. In 2021, The Children's Commissioner reported that one in six children in England had a "probable mental health disorder", up from one in nine in 2017, and that this seemed to be part of a longer-term trend, in addition to what impact the pandemic may have had.[90]

39. For example, according to the charity YoungMinds, between 2010 and 2018–19, the number of young people aged 18 or under attending A&E with a recorded diagnosis of a psychiatric condition at least tripled, and in 2018–19, 24% of 17-year-olds reported they had "self-harmed in the previous year", 7% reported they had "self-harmed with suicidal intent at some point in their lives", and 16% reported they had "high levels of psychological distress".[91]

40. The CfMH's 2020 report on children's mental health and well-being in rural areas described the available evidence as "fragmented" making it difficult to contrast experiences in different areas in a robust way. The picture that did emerge, alongside the start of the pandemic, suggested that children and young people living in remote areas shared various challenges: poor transport infrastructure, fewer local choices, alienation and isolation (especially for those with specific identities or characteristics), poor digital connectivity, a lack of opportunities to socialise outside school and significant barriers to accessing support when needed (all disproportionately impacting children living in poverty, with complex needs or facing other risks of exclusion, alienation and marginalisation). Cuts to public services had made it harder for services to support children in sparsely populated areas, where economies of scale are not achievable, with losses of Sure Start centres, libraries and public transport routes all having an impact.[92] We discuss the Government's announcements of a "Youth Guarantee" and an initial £368 million for youth infrastructure in areas of need later in this Report. However, we note that there was no evidence of specific consideration of the particular needs of rural areas in the allocation of this funding.[93]

41. This was mirrored in other evidence submitted to us. Danny Hutchinson, CEO of West Yorkshire youth mental health charity, Invictus Wellbeing, told us:

> We are seeing increases in self-harm [...] suicide ideation, and real risk-taking behaviours [... and] more demand on the voluntary and community sector to offer support and service around those things. That is a real challenge for us. [...] We have seen [NHS Child and Adolescent Mental

89   Centre for Rural Policy Research (CRPR) University of Exeter (MH0029) paras 9–22; Dr David Rose, Dr Faye Shortland, Dr Paul Hurley et al (MH0007) paras 6–9 and 13–16
90   Children's Commissioner, *The state of children's mental health services 2019/20* (January 2021) p3
91   Young Minds, *Mental Health Statistics* (accessed 7 November 2022)
92   *The space between us* [link], Centre for Mental Health, August 2022; Centre for Mental Health [MH0037], para 3–10
93   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) paras 72–4

Health Service] referrals in our local areas increase two to threefold in the last two years. That has become almost impossible to deal with by statutory services and organisations such as ours.[94]

42.   Karen Black, CEO of the young persons' mental health charity, Off the Record (OTR), which works in Bristol, South Gloucestershire and North Somerset, told us the mental health challenges facing young people in urban and rural areas were broadly similar but presented differently with rural isolation being the key differentiating factor.[95] Dan Mobbs, CEO of a similar charity, the Mancroft Advice Project (MAP), which works in Norfolk, Norwich and Great Yarmouth, said:

> Isolation […] is a huge thing and there are different ways people are isolated— if they are in a minority group for example. Just the fact that they cannot get somewhere and they are stuck in their home and they are dependent on their family [… but public transport and] broadband connections can be really poor.[96]

Karen Black also emphasised that the potential over-exposure of seeking mental health support was a big factor for young people.[97] And Sarah Hughes, CEO of the CfMH, added: "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," and "for people who come from racialised communities, it is particularly difficult if you are the only brown or black child in a school", which can exacerbate a mental health stigma.[98]

Conclusions

43.   **The current data and information relating to the shape and nature of mental health specifically in rural areas, communities and occupations is regrettably incomplete or unavailable and there have been many calls over time for this to be rectified. Given the strong indications of poorer mental health and well-being in rural areas, compared to urban ones, there has been a serious failure of logic and foresight in not ensuring that relevant data are collected and at a very granular level.**

44.   **While experience of nature and the countryside is consistently identified as potentially beneficial for people's mental health, our evidence is equally clear that the isolation inherent in rural living poses a significant challenge to the mental health of those who reside and work in these areas. In addition, other factors represent serious but currently unquantifiable pressures on the mental health of agricultural and veterinary workers.**

45.   **We believe that, while the available evidence does not reveal a mental health crisis in rural England, there are more than enough glaring gaps, and obvious red flags, to warrant urgent and meaningful action, aiming to achieve a degree of preventative impact rather having to wait for an inevitable crisis to create a political imperative and free the necessary resource.**

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94   Q128 [Danny Hutchinson]

95   Qq75–9 [Karen Black]

96   Q79 [Dan Mobbs]

97   Q75 [Karen Black]; The National Rural Mental Health Forum [MH0022] para 10

98   Qq15 and 21 [Sarah Hughes]

46. **In particular, the long list of risks and stressors affecting the farming community and veterinary workers is perhaps the immediate priority, not least because there are real opportunities for substantial gains in this area with significant levers for change in the Government's hands.**

3   Suicide prevention and agricultural and veterinary workers

Public discourse on suicide

47.   Perhaps the starkest and most serious outcome of mental distress is when a person makes an attempt on their own life or they die by suicide. We recognise that every single one of these deaths is a tragedy for families, friends, and communities. On balance we felt it was right to look at the issue of suicide amongst agricultural and veterinary workers, as there is a lot of concern about this incredibly serious issue, and a fuller understanding is needed about what is happening and if enough is being done to address it.

48.   Addressing the topic of suicide is clearly in the public interest as an important part of the impact of poor mental health in general and within particular parts of the population. There are, however, according to our specialist advice, certain parameters to be respected in public discourse on this topic. There is substantial research evidence linking aspects of public analysis and debate around suicide with prompting of harmful exploration of the topic and the incidence of suicide itself. Such aspects largely centre on the inclusion of details and particulars and the over-simplification of causes, triggers, risks and profiles, which can lead to vulnerable people identifying with, or imitating, harmful behaviours.

49.   This chapter looks at the national picture and rural context and then examines the prevalence of suicide amongst two broad occupational groups; how national and local government are responding through suicide prevention work; and the potential contribution of a more joined-up public health approach. **Please note, this chapter raises issues which the reader may find upsetting (and we draw attention to the resources set out at the start of this report which may provide recourse).**

Suicide prevalence: the national picture and rural context

50.   The Office for National Statistics' (ONS) definition of suicide "includes deaths with an underlying cause of intentional self-harm (ages 10 years and over) and deaths with an underlying cause of event of undetermined intent (ages 15 years and over)."[99] Chart 1 shows the trend in the number of suicides since 1981 and the age-standardised mortality rate from suicide in England and Wales.[100] Since that year there has been a 28% decline in the suicide rate—this mostly occurred before 2000 but has since fluctuated, see Figure 4.[101]

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99   Office for National Statistics, *Suicide rates in the UK QMI: Quality and Methodology Information for suicides in the UK, detailing the strengths and limitations of the data, methods used, and data uses and users* (April 2019). Note: suicide data is based on the date of registration of death, which takes place after an inquest and can sometimes take more than a year.

100   *Suicide statistics*, House of Commons Library, December 2022, p4. Note: the age-standardised mortality rate, "takes into account changes in population size and structure. For example, while the number of suicides registered in 2020 was 11% higher than in 2005, the suicide rate was similar, because the population has risen."

101   *Suicide statistics*, House of Commons Library, December 2022, p4

Figure 4: Suicide in England and Wales since 1981 Age-standardised rate per 100,000 population, by year of registration
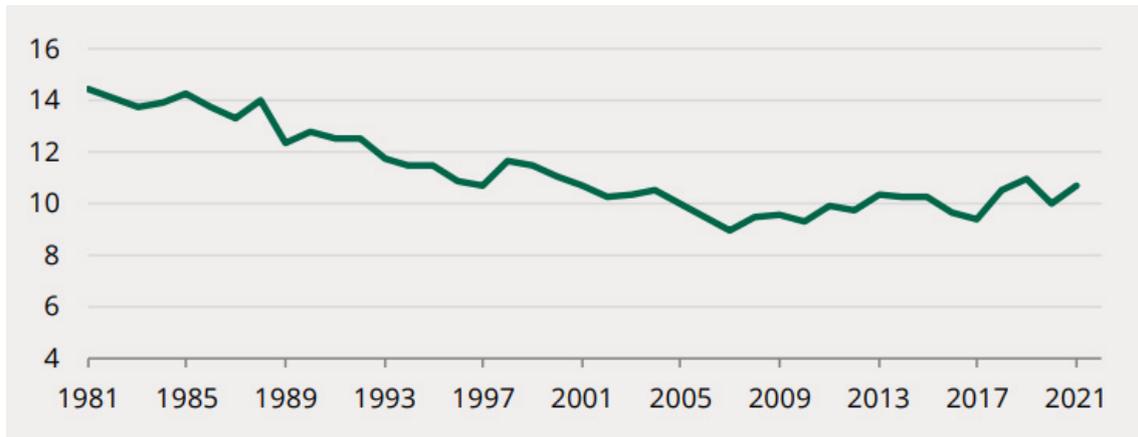
Source: ONS, *Suicides in England and Wales: 2021 registrations* tables, Table 1 (September 2022), cited in *Suicide statistics*, House of Commons Library, December 2022, p5

The data behind the graph also show that: since 1981, in England and Wales, suicide was three times more common among men than women and the rate among women fell by around 50% over this period and by 17% among men.[102] Data for 2021 show the risk of suicide was highest for people aged 45 to 54 and lowest for people aged under 20 and over 70. Also, that the risk of suicide amongst people living in England's most deprived 10% of areas in 2017–2019 was 14.1 per 100,000, whereas it 7.4 per 100,000 in the least deprived decile.[103]

51.   Rural circumstances may also be a a possible risk factor in suicide, according to research cited in Samaritans' written evidence, along with deprivation and social fragmentation for total suicide mortality.[104] However, as with rural mental health overall, the available data and research is unclear about the extent of the association, for example ONS research from 2020 showed that "suicides among men living in rural towns and 'fringes' rose by 23.6% between 2016 and 2018, but the rate fell in rural villages, compared to urban cities and towns.[105]

Agricultural workers

52.   In 2020, about 472,000 people worked in UK farming.[106] Evidence provided by Samaritans, drawing on a 2017 ONS-analysis of deaths from suicide in different occupational groups for people aged 20 to 64 years, registered in England between 2011 and 2015, showed that people working in agriculture were more likely to die by suicide than those within the general population, 1.7 times more likely if they worked in skilled agricultural and related trades, and twice as likely if working in "elementary agricultural

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102   *Suicide statistics*, House of Commons Library, December 2022, p6

103   *Suicide statistics*, House of Commons Library, December 2022, p4–11

104   Samaritans (MH0012) para 5 citing Peter Congdon, *Assessing the impact of socioeconomic variables on small area variations in suicide outcomes in England*, *International journal of environmental research and public health*, Vol. 10, Issue 1 (January 2013), pp 158–177

105   Samaritans (MH0012) para 5 cited Office for National Statistics, *Recent trends in suicide: death occurrences in England and Wales between 2001 and 2018* (8 December 2020). The ONS states, "of the different kinds of rural and urban areas, cities and towns accounted for the most suicides during the period, 48.1% (or 5,616 out of the 11,669 male suicides between 2016 and 2018)."

106   Department for Environment, Food and Rural Affairs, *Farming statistics - final crop areas, yields, livestock populations and agricultural workforce at 1 June 2020 United Kingdom* (December 2020) p21

occupations such as harvesting crops.[107] However, Samaritans told us the higher-than-average suicide rate amongst agricultural workers was "a nuanced issue, with specific occupational subgroups at higher risk."[108] Samaritans cited ONS analysis of data from 1991 to 2000 which suggested farmers "may be at increased risk of suicide"[109] and its subsequent findings, in 2017, based on data from between 2011 to 2015, which indicated that the suicide rate amongst farmers was not above the national average (whilst it remained high among other jobs in the "skilled agricultural and related trades" occupational group, such as gardeners).[110]

Veterinary workers

53. In 2019, there were around 25,870 UK-practising veterinary surgeons and 17,168 veterinary nurses.[111] There is not extensive evidence on suicide for people in these roles; but a 2010 review of international research found the rate of suicide in the veterinary profession in the UK "was at least three times the general population rate", and several other countries' veterinary professions also had higher rates of suicide.[112] The ONS's 2017 analysis of deaths from suicide in different occupational groups referred to vets being at "increased risk of suicide" alongside doctors, dentists, nurses and agricultural workers. But it was based on data from 1991 to 2000 and the ONS has not provided more recent data for vets unlike agricultural workers.[113] The charity, Vetlife, which provides mental health support to the veterinary community, stated in its 2020 annual report and accounts that the community "continue[d] to experience high levels of poor mental health and suicide". Its Helpline received almost 4,000 contacts, an increase of 25% in 2020, and it was continuing to support practices "following bereavement by suicide".[114] Vetlife, run by Dr Rosie Allister of Edinburgh University, told us in oral evidence that "suicide rates in the veterinary profession have been elevated for a long time", and a lot of the pressures facing farmers "are shared with the veterinary community", with whom they work closely.[115]

Data quality and methodological implications

54. A number of respondents highlighted limitations in the available data. The NFU said care must be taken when discussing suicide by occupation as the data are often not detailed nor robust enough to support conclusive findings.[116] Suicides may also be under-reported as part-time agricultural workers are not recorded in the statistics; suicides may be reported as accidents; figures by occupation only include people up to the age of 65,

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107   Samaritans (MH0012) para 11 cited Office for National Statistics, *Suicide by occupation, England: 2011 to 2015* (17 March 2017)

108   Samaritans (MH0012) para 11

109   Samaritans (MH0012) para 11, cited Jameson K Hirsch, *A review of the literature on rural suicide: risk and protective factors, incidence, and prevention*, Crisis, Vol 27, Issue 1, (2006) pp 189–99

110   Samaritans (MH0012) para 11, cited Office for National Statistics, *Suicide by occupation, England: 2011 to 2015* (17 March 2017)

111   Royal College of Veterinary Surgeons, RCVS Facts 2019 (August 2022) pp4–8

112   B. Platt, K. Hawton, S. Simkin, R. J. Mellanby, *Systematic review of the prevalence of suicide in veterinary surgeons*, Occupational Medicine, Vol 60, Issue 6, (September 2010), pp 436–446

113   Office for National Statistics, *Suicide by occupation, England: 2011 to 2015* (17 March 2017)

114   Vetlife, *Annual Report and Accounts* (31 December 2020) pp7 and 12

115   Q109 [Dr Rosie Allister]

116   National Farmers' Union (MH0028) paras 12–13

excluding those working after traditional retirement age. With over a third of farm holders in England over 65 years old,[117] according to DEFRA, there is a question over the accuracy of these figures.

55. There is also the time lag in reporting that occurs because entering a death as a suicide in official data requires an inquest to be completed which can take months or even years.[118] We heard that a "real-time surveillance system" is needed to provide data more quickly on suspected suicides to enable more responsive and targeted interventions to tackle emerging trends. Furthermore, qualitative information should be used alongside the statistics, such as people's experiences in agricultural and veterinary occupations who have experienced suicidal thoughts; or interviews of coroners and local people to build a fuller picture of relevant cases.[119]

Factors that may play a role in suicide amongst agricultural and veterinary workers

56. According to Samaritans explaining suicide amongst occupational groups is complicated as "numerous factors act together to increase risk."[120] Its written evidence highlighted some of the factors which may help to explain higher levels of suicide among some agricultural occupations are:

- Gender, as "around three-quarters of registered suicides occur among men" who are very over-represented in agricultural work

- A "strong socioeconomic gradient" as "men from the most disadvantaged backgrounds are up to ten times more likely to die by suicide than those in more affluent areas"

- the highest suicide rates are "among workers who are worse-paid and have less control over their work" (and the lowest rates are amongst those in "highly-paid occupations")

- Samaritans cited ONS's 2017 research conclusion, "it may not be the actual occupation that puts individuals at risk, but features of the job", like low pay, job security and the socio-economic features of people working in a sector, and

- Evidence of higher rates of depression, anxiety, PTSD, and suicidal thoughts amongst people in low-paid agricultural work such as seasonal workers or temporary migrant workers who are at risk of, or experiencing, labour exploitation or modern slavery.[121]

57. Written evidence from the Centre for Rural Policy Research (CRPR) cited research that factors that may explain a higher rate of suicide amongst agricultural workers are, "a combination" of access to means, being more familiar with death than most people in the wider population, and being more likely to know someone who has died by suicide.[122]

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117 Department for Environment, Food and Rural Affairs, *Agriculture in the UK Evidence Pack* (September 2022 Update) p8
118 National Rural Mental Health Forum (MH0022) para 13; Q205 [Jacqui Morrissey]
119 Qq204–05 [Jacqui Morrissey]; Q207 [Kate Miles]; Q208 [Professor McManus]
120 Samaritans (MH0012) para 12
121 Samaritans (MH0012) paras 12–14
122 Centre for Rural Policy Research, University of Exeter (MH0029) para 30

The British Association of Counselling and Psychotherapy highlighted that a review of published literature indicates some of the other risk factors (which overlap with many of the mental health stressors in chapter 2) may be rural isolation, including geography, social, and cultural; financial worries; and factors beyond their control, such as the weather and disease. And preferring to "manage themselves" instead of accessing help perhaps due to a lack of awareness about mental health services, or structural barriers including geographical location and decline in rural infrastructure.[123]

58. A complicated range of risk factors will also be at work for veterinary workers. In addition to key sources of stress affecting veterinary mental health highlighted in chapter 2;[124] Dr Allister of Vetlife highlighted the following factors in the high incidence of suicide amongst veterinary workers:

- moral injury from having to decide whether to work and leave no veterinary care in place for their area or take time off sick[125]

- feelings of burdensomeness, blame and shame preventing the seeking of help, with vets finding it difficult to ask for help given their caring role[126]

- Worry and fear of disciplinary action about if they disclose concerns about their mental health and whether this will lead to them not being able to do their job anymore, which is a large part of their identity[127]

- NHS support being withheld due to an assumption that people still working are not unwell enough to merit assistance and therefore do not meet the threshold for mental healthcare[128]

- the high number of students or practising vets bereaved by suicide and research indicating that some students may feel that encountering suicide is likely in their career, and

- Vets' access to medicines and firearms often associated with veterinary suicide (but so do other professions which do not have the same elevated suicide rates).[129]

National suicide prevention policy

59. The then Coalition Government's original 2012 Suicide prevention strategy for England stated that it aimed to reduce the suicide rate in the general population and better support people bereaved or affected by suicide. At that time, it identified "high risk" occupational groups including veterinary workers, farmers and agricultural workers as "priorities for prevention."[130] The strategy had seven areas for action which included, reducing the risk of suicide in key high-risk groups, supporting research, data collection and monitoring and reducing rates of self-harm as a key indicator of suicide risk. The

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123   British Association for Counselling and Psychotherapy (BACP) (MH0021) para 20

124   Qq109–111 [Dr Allister; James Russell]; Q218 [Kate Miles; Bovine Tuberculosis Partnership for England [MH0030] paras 7–11, 13–14.

125   Q116 [Dr Allister]

126   Qq108, 112, 116 [Dr Allister]

127   Qq108, 112, 116 [Dr Allister]

128   Q108 [Dr Allister]

129   Qq112–13 [Dr Allister]

130   HM Government, *Suicide prevention strategy for England* (December 2012) p5

Government added the last action to the strategy with its third progress report in 2017 which said, in light of the Health Committee's 2016 interim report on *Suicide prevention*, that every local area should develop a multi-agency suicide prevention plan.[131]

60. The strategy also contained references to:

- the preparedness of rural GPs to assess and manage depression and suicide risk amongst vulnerable farmers and agricultural workers

- specific support on bovine tuberculosis via the Farm Crisis Network

- a rural stress helpline offering a confidential, non-judgemental listening service, and

- a Task Force on Farming Regulation to reduce the bureaucratic burden on farmers.[132]

61. However, in 2019, when the Government produced its *Cross-government suicide prevention workplan*—to support delivery of the strategy and commit every part of Government to take action on suicide, there was no reference to rurality, a helpline, nor deregulation of agriculture, green social prescribing or rural proofing policy.[133] Key actions included initiatives aimed at men generally, and specific groups presumably identified as at risk, such as mental health inpatients, military veterans, those in custody, gamblers, sportspeople, the LGBT community, students and other young people (but not veterinarians, farmers nor other agricultural workers).[134] In the event, the *Workplan* missed its target, set in 2016 by the independent Mental Health Taskforce to the NHS in England, to reduce the rate of suicides in England by 10% by 2020 against 2015-levels.[135]

62. DEFRA's evidence to our inquiry acknowledged that no "specific reference" had been made to the "high-risk" occupational groups originally identified by the 2012 strategy, either in recent progress reports or in the *Cross-government suicide prevention workplan*.[136] This raised questions about how targeted the Government's suicide prevention work is, a concern reflected in some of the other evidence we received. For example, Sarah Hughes of the CFMH told us the strategy did not "meet the needs of rural communities in terms of suicide prevention", as it is not currently "a priority" nor "prominent."[137] She also said

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131   Department of Health and Social Care, *Suicide prevention: third annual report* (January 2017) p4; Health Committee, *Suicide prevention: interim report*, 19 December 2016, HC 300 2016–17. Note: the revised strategy also said local areas should improve suicide bereavement support to develop support services; better target suicide prevention and help seeking in high-risk groups; and improve national and local data.

132   HM Government, *Suicide prevention strategy for England* (December 2012)

133   HM Government, *Cross-government suicide prevention workplan* (January 2019) p2

134   HM Government, *Cross-government suicide prevention workplan* (January 2019) pp7, 11–40 Note: Generic reference was made to PHE issuing advice to employers of high risk occupational groups (identified by Office for National Statistics, *Suicide by occupation, England: 2011 to 2015*), and that DHSC and the Minister for Suicide Prevention would engage with high risk sectors about suicide awareness and prevention.

135   HM Government, *Cross-government suicide prevention workplan* (January 2019) p6; Mental Health Taskforce to the NHS in England, *Five Year Forward View for Mental Health* (February 2016) p13; *Suicide prevention: Policy and practice,* House of Commons Library, February 2022, p9; Q224 [Jacqui Morrissey]; Samaritans (MH0042) p1

136   Department for Environment Food & Rural Affairs (MH0036) para 17; HM Government, *Cross-government suicide prevention workplan* (January 2019); Department of Health and Social Care, *Suicide prevention in England: Fourth annual report* (January 2019), and *Suicide prevention in England: fifth progress report* (March 2021)

137   Q49 [Sarah Hughes]

national suicide prevention campaigns like *Every Mind Matters* do not "land well" in rural areas because of how they talk about "access to services and self-care", indicating they are focused on urban communities.[138]

63.   We asked the Government why it was not doing more to address suicide amongst agricultural and veterinary workers. It told us it had been focused on "new actions taken to mitigate suicide risk factors" and wider population groups during the pandemic, such as middle-aged men who are known to be at higher risk of suicide (which would include many who work in agriculture).[139]

64.   The Government is confident that its consultation for a new 10-year *Cross-government mental health and wellbeing plan* will strengthen its future approach to suicide prevention. However, in the documentation behind this plan, DEFRA's contribution was framed in terms of the provision of "green social prescribing" and there was no reference to any of the occupational groups that the ONS has designated as at elevated risk and are within DEFRA's portfolio.[140] The Samaritans' written evidence commented this policy may support the broader population's mental health, but is only "a fraction of the wide-ranging public health approach needed to address the specific factors associated with suicide among people living and working in rural areas."[141]

65.   The DHSC announced in January 2023 that the expected *Mental health and well-being plan* would instead be rolled into a much broader "Major Conditions Strategy", covering mental health and five other broad health conditions, with a separate suicide prevention strategy still to be produced separately during 2023 but for which no information on process or timetable is yet available.[142]

66.   **DEFRA should be an active stakeholder in any national suicide prevention strategy, as the Department is responsible for populations and occupational groups arguably at higher-than-average risk of poor mental health and death by suicide.[143] However, DEFRA does not appear to have carved out a clear role in the last two initiatives—the national strategy and cross-government workplan—and its only reference in the latest consultation is to managing "green social prescribing".[144]**

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138   Q49 [Sarah Hughes]; NHS *Every Mind Matters* [accessed 17 October 2022]

139   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) paras 49–51

140   Department of Health and Social Care, *Mental health and wellbeing plan: discussion paper* [accessed 17 October 2022]; Q321 [Gillian Keegan]; Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) paras 36 and 40

141   Samaritans (MH0012) para 21; Dr Kreseda Smith (MH0005) para 22

142   Department of Health and Social Care, *Mental health and wellbeing plan: discussion paper and call for evidence* (January 2023); HC Deb, 24 January 2023 HCWS514 [Commons written ministerial statement]. The other conditions are, cancers; cardiovascular diseases, including stroke and diabetes; chronic respiratory diseases; dementia; and musculoskeletal disorders.

143   Samaritans (MH0012) para 21; Department of Health and Social Care, *Suicide prevention in England: fifth progress report* (27 March 2021) p30

144   Department of Health and Social Care, *Suicide prevention in England: fifth progress report* (27 March 2021) p30; Department for Environment, Food and Rural Affairs, *Rural Proofing in England 2020 Delivering policy in a rural context* (March 2021) p42–3, Department for Environment, Food and Rural Affairs, *Delivering for Rural England – the second report on rural proofing* (September 2022) p28–9; Q298 [Lord Benyon]; Department for Environment Food & Rural Affairs (MH0036) paras 24–6

Local suicide prevention

67.   Local authorities carry much responsibility for delivering the national plan as, since 2013, suicide prevention has been part of their "responsibilities for leading on local public health and health improvement".[145] PHE's advice to local authorities is that local suicide prevention plans should, aim to tackle the seven strands of the national strategy, focusing on short-term priorities.[146] In 2017, the Health Committee's *Suicide prevention* report found 95% of local authorities had a suicide prevention plan "in place or in development", but the Committee was concerned about their quality and called on the Government to establish a robust quality assurance process.[147] In 2019, The *NHS Long Term Plan* (LTP) stated that all English local authorities had put "multi-agency suicide prevention plans in place", and an independent progress report by Samaritans and Exeter University found most local authorities had established an action plan and included PHE's recommended priorities for action; but not all had turned their plans into action.[148] In oral evidence Jacqui Morrissey of Samaritans (one of the progress report's authors) told us good progress had been made in delivering the national strategy as every local area now has a suicide prevention plan focused on understanding and responding to local community need.[149] On the other hand, Sarah Hughes of the CFMH said local plans were "still fairly new [… but] do not suitably reflect the need of rural and coastal communities well enough".[150]

68.   We asked Claire Murdoch, NHSE's National Director for Mental Health, how well the NHS is working with partner bodies to reduce suicide prevalence amongst agricultural and veterinary workers. She told us it is wholly focused on funding and supporting local areas to come up with their own multi-agency plans.[151] However, NHSE told us they do not have a role in reducing suicide prevalence amongst agricultural and veterinary workers, beyond setting "high level strategy and targets", whilst Integrated Care Boards (ICBs) allocate their resources to places and different services within their Integrated Care System (ICS), work with their partners and the local community, to develop and invest in services to match their communities' needs.[152] We also asked NHSE what metrics and targets the NHS is using to measure "success" in terms of fewer suicides but it said only the ONS keeps data on registered suicides.[153]

Funding

69.   DHSC's recent funding for suicide prevention includes:

- Almost £600,000 in 2019/20 with more funding in 2021/22 spent via the LGA to help strengthen local authorities' plans

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145   HM Government, *Cross-government suicide prevention workplan* (January 2019) p8. *The Health and Social Care Act 2012* Part 1 (Section 31) gave local authorities more powers and responsibilities over public health under the NHS.

146   Public Health England, *Local suicide prevention planning: A practice resource* (October 2014, updated September 2020) pp8–9, 11

147   Health Committee, *Suicide prevention* (March 2017) p9

148   NHS England, *The NHS Long Term Plan* (January 2019) p72; Samaritans and University of Exeter, *Local Suicide Prevention Planning in England: An independent progress report*, Tom Chadwick, Christabel Owens and Jacqui Morrissey (May 2019) p2

149   Q224 [Jacqui Morrissey]

150   Q49 [Sarah Hughes]

151   Q289 [Claire Murdoch]

152   NHS England (MH0044) para 15

153   NHS England (MH0044) para 14

- £57 million by 2023/24 under the NHS LTP to support local suicide prevention plans and develop suicide bereavement services

- Almost £5.4 million in 2021/22 to support suicide prevention voluntary and community sector organisations, and a £4 million Suicide Prevention Grant Fund from December 2021 for voluntary and community sector organisations to continue to provide suicide prevention services—which we understand has now ended.[154]

70. We heard concerns about a lack of adequate and long-term government funding for suicide prevention. Samaritans told us the Autumn 2021 Spending Review did not include renewed funding for local suicide prevention, when there are "stark regional inequalities in suicide".[155] £25 million of the £57 million allocated to local areas for suicide prevention and bereavement services under the NHS LTP "ran out in 2020/21".[156] It also pointed out this funding "was not specifically for agricultural mental health but [was] meant to be used in areas with the highest suicide rates overall and among at-risk groups."[157] Samaritans called for ringfenced funding over three years to help local areas "develop and deliver targeted non-clinical support services to prevent suicide."[158] However, it pointed out that remaining funding for local authorities' core suicide prevention plans stops in 2023/24, and said the Government must urgently commit ongoing funding to support them, in line with NHS LTP commitments, instead of being down to local discretion.[159] Local authorities do not have other resources to fill the funding gap and Professor Jim McManus of the UK Association of Directors of Public Health told us that the public health budget had been reduced "by over 25% in four years" and national funding is all they have for suicide prevention.[160] Otherwise, he said that suicide prevention work which save lives "will stop" if there is not dedicated national funding to deliver it.[161]

71. Professor McManus also said the current NHS-funding formula leads to spending on suicide prevention funding being "weighted" to urban deprivation rather than rural deprivation, so rural areas "inevitably lose out", which he suggested needed correcting.[162] Professor McManus and Jacqui Morrissey of Samaritans both stressed the key role of local suicide prevention partnerships in being able to identify at risk-groups in rural areas, and direct NHS funding via voluntary and community organisations to provide targeted non-clinical support services to groups at highest risk.[163] However, DEFRA and DHSC told us in summer 2022 that, "beyond 2023/24, no decisions have been made on future

154   Department for Environment Food & Rural Affairs (MH0036) paras 10–11; Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045), para 47

155   Samaritans (MH0012) para 18; HM Treasury, *Autumn Budget and Spending 2021: A stronger economy for the British People* (October 2021)

156   Samaritans (MH0012) para 18

157   Samaritans (MH0012) para 18

158   Samaritans (MH0012) para 18

159   Samaritans (MH0012) para 18

160   Q224 [Professor McManus]

161   Q224 [Professor McManus]

162   Q226 [Professor McManus]

163   Q228 [Professor McManus]; Q227 [Jacqui Morrissey]

dedicated funding for suicide prevention."[164] £10m of funding subsequently announced by the Chancellor in the Spring 2023 Budget was directed to the voluntary sector but *not* local government.[165]A joined-up public health approach

72. Samaritans said that the broad range of factors that created a heightened suicide risk in rural communities and occupations meant "suicide prevention services" is "an extremely broad term" covering a wide range of bodies.[166] It said this is because about "two thirds of people who take their own lives are not in touch with [NHS] mental health services in the year before they die." As such, a more joined-up public health approach to suicide was required where every part of local and national government should adopt policies "to prevent people from ever reaching the point of wanting to take their own life and needing crisis intervention."[167] We also heard that the NHS needed to be more focused on early intervention.[168] For example, Dr Allister of Vetlife told us the NHS needs to provide care for veterinary workers "who are suicidal, not based around diagnosis, but if you are suicidal and you present to health services a guarantee that there will be help".[169]

73. Samantha Allen, CEO of the North-East and North Cumbria ICB, told us its local multi-agency suicide prevention plan focuses on specific groups, with targeted campaigns including 24/7 crisis lines.[170] She acknowledged that the NHS needed to better understand the specific needs of rural communities, including veterinary and farming communities, and to improve the relevant staff training, including about things which are not necessarily "protective factors" (such as holidays for agricultural workers because of the difficulties of them being able to take time off work).[171] The ICB said it needed to use the data it collected to prioritise and focus suicide prevention work and co-design solutions with community and voluntary sector organisations to meet local communities' needs.[172]

74. From a secondary care perspective, Dr Jaspreet Phull of Lincolnshire Partnership NHS Foundation Trust (LPNFT) stressed that suicide prevention for agricultural and veterinary workers must focus on ensuring access to support is right, with their local strategy being for the whole community, not just mental health providers.[173] So, locally, for example, the Trust was engaging with farmers' unions and local farmers' networks and the Lincolnshire Show, in order to talk to farmers and agricultural workers and try and normalise discussions around mental health; engaging, for instance, with agricultural chaplaincies to help people get signposted to mental health support.[174]

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164   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 48

165   HM Treasury, Spring Budget 2023 (March 2023) p83 Note: The Budget states that under the Suicide Prevention Voluntary, Community and Social Enterprise (VCSE) Grant Fund, "the government will make £10 million available for a grant fund for suicide prevention VCSE organisations in England across 2023–24 to 2024–25 to support people experiencing suicidal thoughts or approaching a mental health crisis."

166   Samaritans (MH0012) para 17

167   Samaritans (MH0012) para 17

168   Q124 [Dr Allister]

169   Q124 [Dr Allister]

170   Q290 [Samantha Allen]

171   Q290 [Samantha Allen]

172   Q290 [Samantha Allen]

173   Q260 [Dr Phull]

174   Q260 [Dr Phull]

Practical suicide prevention

75.   We heard that a joined-up public health approach also needed to include practical suicide prevention and training. This included helplines which people can contact at any time run by trained staff or volunteers provided by suicide prevention, agricultural and veterinary charities.[175] Such an approach would also include suicide prevention training such as "ASIST" which could teach people, without previous mental health or suicide prevention experience, how "to recognise when someone may have thoughts of suicide and work with them to create a plan that will support their immediate safety."[176]

76.   We also heard that training individuals in suicide prevention techniques needed to be combined with raising broader awareness amongst rural communities. For example, the farming charity YANA's national suicide prevention campaign, called *7 Tractor Facts to Save A Life,* is aimed at the farming and rural sector, covering seven steps anyone can take to support someone in crisis and where they can get further help.[177] In Wales the DPJ Foundation runs what it describes as bespoke "Mental Health Awareness Training" including suicide awareness, which aims to "give the agricultural community the ability to support each other and be confident in spotting the signs of poor mental health and signposting onwards".[178] In oral evidence Kate Miles, the Foundation's Charity Manager, said the organisation had trained people who work with farmers and visit farms, such as vets, postal workers, farming unions, fallen stock collectors and rural police forces; and supplemented rural nurses' and trainee doctors' mental health training, so they are "better equipped and more confident".[179]

Workplace environments and culture

77.   We also heard that a joined-up public health approach to suicide prevention needed to address the working culture and environment of agricultural and veterinary workers. In 2021, Dr Allister of Vetlife had publicised key steps for suicide prevention in veterinary practices to build a positive culture that supported mental health.[180] Professor McManus's evidence also emphasised the importance of building what he called "a positive psychosocial environment" in workplaces, requiring trained managers to support staff, build behaviours and train staff to openly communicate if all is not well, and provide informal opportunities to raise concerns.[181]

78.   It may be more challenging to provide effective support to lone workers around mental health and suicide prevention, given how isolated—socially and/or geographically—some agricultural and veterinary workers' lives can be.[182] In these cases, action may be needed across rural communities or the local economy to reach people. Jacqui Morrissey of Samaritans suggested that it was necessary to look at: the wider community and social

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175   Samaritans (MH0012) para 1; Farming Community Network (MH0009) para 1; Q107 [Dr Allister]

176   Grassroots, *ASIST: Applied Suicide Intervention Skills Training - Suicide Prevention Training* [accessed 20 December 2022]

177   Q168 [Melinda Raker]; YANA (MH0011) paras 10–11

178   Qq202 and 218 [Kate Miles]; DPJ Foundation, *Mental Health Awareness Training*; DPJ Foundation *Report of the Trustees and Unaudited Financial Statements* (March 2021) p1

179   Q218 [Kate Miles]

180   See Dr Rosie Allister, *Five evidence-based steps for suicide prevention in veterinary practices,* Improve Veterinary Practice (May 2021)

181   Q221 [Professor McManus]

182   Q171 [Stephen Dodsworth]; Q175 [Edward Richardson]; Q110 [James Russell]; Qq109 and 111 [Dr Allister]; Q223 [Jacqui Morrissey]

connections in which lone workers live and work; with whom they come into contact; and good access for people to support in the right places when needed.[183] One example is auction marts which have regular contact with the farming community and could provide a good venue for charity or primary care support (see Chapter 4).[184] Another example is the charity the DPJ Foundation being commissioned by a supermarket to deliver mental health awareness training to farm suppliers, and training people who visit farms, (i.e. vets, postal workers, farming unions, rural police).; and preparing the ground by working with agricultural college faculties and students before they enter the industry, to equip them in looking after their mental health and be aware of support for suicide prevention.[185]

79. **Adopting a more joined-up approach to public health focused on early intervention could make a positive contribution to preventing suicide amongst agricultural and veterinary workers. It would need to 'wrap-around' people at potential risk, incorporating the NHS, other key public services and the regular contacts that people have in their local community or economy, and be under-pinned by training in suicide prevention, and efforts promote working and workplace cultures that support good wellbeing.**

The Government's approach

80. We considered how far the Government's current and planned approach met the proposals for a more joined-up public health approach to suicide. DEFRA and DHSC acknowledged the role of local community groups and agricultural charities that are "best placed to support in times of mental health crisis, due to their vast local network and specialised knowledge" and DEFRA is supporting this through the Farm Resilience Fund.[186] Other bodies are also making similar preparations: Rural Payments Agency (RPA) staff had received new training in how to identify and deal with anxiety; its field officers were provided with information on signposting farmers to professional support; and Animal and Plant Health Agency staff had received health and safety guidance on how to deal with a person at risk of self-harm or suicide.[187] DEFRA and DHSC also stressed how important it is to address "the social, economic and health factors […] from the pandemic that could lead to an increase in suicide risk [… and] pre-existing risks," so had set up a Ministerial Task and Finish Group to review progress of the Government's *COVID-19 mental health and wellbeing recovery action plan*.[188]

81. **We are very concerned by the evidence indicating that agricultural and veterinary workers have a higher-than-average suicide rate compared to the rest of the population. Although more accurate information is needed, a clear enough picture was already established for the Government's national suicide prevention strategy (published over ten years ago) to identify both as high-risk occupational groups and take clear steps to improve the situation. Given this, we were dismayed by the lack of focus on**

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183   Q223 [Jacqui Morrissey]

184   Q169 [Stephen Dodsworth]; Centre for Rural Policy Research (CRPR) University of Exeter (MH0029) para 30

185   Q2q218–222 [Kate Miles]

186   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 55

187   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) paras 56–7

188   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 58; Department of Health and Social Care and Cabinet Office, *COVID-19 mental health and wellbeing recovery action plan* (March 2021)

them evident in recent strategy progress reports and the cross-government suicide prevention workplan. Compared to other departments of state and their client groups, whether prisoners, military veterans or those in serious debt, DEFRA appears to have a very limited role in this area. The Government should address this shortcoming by creating clear objectives and actions when revising the national strategy.

82. **Local government is carrying a substantial proportion of the responsibility for delivering the existing national strategy through local suicide prevention plans. However, it is unclear how much these have identified, or address, the specific needs of rural areas. Finally, we are very concerned that core local funding is not ringfenced.**

83. *We recommend that the Government:*

a) *confirm the timeline and consultation process for revising the new National Suicide Prevention Strategy*

b) *confirm and ringfence additional funding beyond 2023/24 for local suicide prevention to allow local authorities to contribute effectively to delivery of the national strategy, and*

c) *commission the ONS to work with DEFRA and DHSC to address gaps in the suicide data and investigate establishing a 'real-time surveillance system' to identify trends in suicide by occupation to inform prevention policy action on suicide prevention in relation to agricultural and veterinary workers.*

During the development of the new suicide prevention strategy, DEFRA must do better to push rural and agricultural mental health priorities to the fore, seizing a substantial role and commensurate resources to deliver progress. The Department should also establish a National Working Group on agricultural and veterinary occupations to identify immediate priorities and actions to promote more effective suicide prevention for these groups, and to develop a more joined-up public health approach to suicide prevention across the NHS, public sector and local communities.

4 Rural mental health service provision, policy and strategy development

Rural proofing

84. Rural Proofing was introduced by the Government in the 2000 Rural White Paper to ensure that "the specific challenges faced by rural communities are effectively understood and reflected in policy".[189] DEFRA told us that it leads for the UK Government on working to help other departments and public bodies to ensure that "the specific challenges faced by rural communities are effectively understood and reflected in policy".[190] DEFRA's 2017 guidance, entitled *Rural Proofing,* states the process "is about understanding the impacts of policies in rural areas", to ensure they "receive fair and equitable policy outcomes," and sets out four stages, for such a policy appraisal shown in Table 1 below.[191]

Table 1: Rural proofing process

Stage	Key question	How can this question be answered?
1	What are the direct or indirect impacts of the policy on rural areas?	To identify if a policy intervention is likely to have an impact on rural areas, you should review available evidence and, where necessary, consult rural stakeholders.
2	What is the scale of these impacts?	The focus of this assessment should be on the change that occurs as a result of the policy intervention. Your analysis should help you understand if the impact in rural areas is different to urban areas and the scale of the impact
3	What actions can you take to tailor your policy to work best in rural areas?	Where you have identified rural impacts that are different to urban impacts and are large enough to warrant mitigation, you should look to tailor the policy to ensure that it is delivered in a way that addresses the needs of rural areas.
4	What effect has your policy had on rural areas and how can it be further adapted?	Rural proofing should be applied at all stages of the policy cycle, including after the policy has been implemented. Where you find rural issues to be significant, this should be considered as part of the monitoring and evaluation phase and included in the Post Implementation Review or evaluation plan.

Source: Department for Environment, Food and Rural Affairs, *Policy paper: Rural proofing - Practical guidance to assess impacts of policies* (March 2017) p1

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189 Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 2

190 Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 2. Note: Rural Proofing was introduced by the UK Government in the 2000 *Rural White Paper*. Successive administrations have applied rural proofing practices and principles in different ways (for example, by the Countryside Agency, 1999–2005, the Commission for Rural Communities, 2006–2013) both with responsibility for advising government departments. In 2010, the then Coalition Government brought the process inside the DEFRA where the "Rural Communities Policy Unit" now leads rural proofing.

191 Department for Environment, Food and Rural Affairs, *Rural proofing - Practical guidance to assess impacts of policies* (March 2017) Pp1–19

Does national mental health policy meet rural communities' needs?

85.   DEFRA and DHSC told us they work together "to improve the accessibility and provision of health and mental health services in rural areas", acknowledging that DHSC was the policy lead.[192] However, some respondents were concerned about how effectively mental health policy has been "rural proofed". The NRMHF, based in Scotland, said each government department "should take into account mental health in their decision making" to ensure there is "mental health proofing of policy and decisions".[193] The Dorset-based social enterprise, RMHM, told us that statutory and non-statutory organisations needed support from a properly funded and accountable national body to give oversight, to help them "achieve rural inclusiveness, and ensure they 'rural proof' their support/services", and could be modelled on the NRMHF which has been "the voice" of rural Scotland.[194]

86.   We heard that there was limited joined up working between the UK Government and organisations supporting rural or farming mental health. Evidence from the research group led by Dr Rose of Reading University said, "DEFRA and its arms-lengths bodies do not appear to have dedicated teams thinking about supporting rural mental health", and DEFRA needed to "articulate what its role is in supporting" civil society organisations that help the farming community.[195] Dr Rose told us support for farming mental health in Northern Ireland is "much more joined up" under the Department of Agriculture, Environment and Rural Affairs, working with the charity Rural Support, which is "the go-to place to support farming mental health" in Northern Ireland.[196] By contrast, he said DEFRA's evidence to our inquiry suggested that rural mental health in England "falls between" DEFRA, DHSC and the Health and Safety Executive, with DEFRA not "clear" on its role.[197] Dr Jude McCann, from the Farming Community Network (FCN) and previously Rural Support's CEO, told us every policy in Northern Ireland has been rural proofed, something that is "missing" in England.[198]

87.   We asked Lord Benyon how DEFRA engaged with the NHS on rural mental health. He cited DEFRA attending DHSC-chaired meetings of the Ministerial Task and Finish Group on Mental Health and Wellbeing; DEFRA working on mental health in the *Green Social Prescribing* programme encouraging people to "connect with the natural environment"; and DEFRA helping other departments rural proof their policies, specifically referring to the publication of DEFRA's second rural proofing progress report.[199] The only national mental health policy in the first or second progress reports from 2021 and 2022 is green social prescribing. However, it is unclear how this represents a properly 'rural proofed' mental health policy, as assumptions and perceptions that the rural environment represents only a positive mental health intervention seem to be part of the problem we

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192   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 2

193   National Rural Mental Health Forum (MH0022) para 23

194   Rural Mental Health Matters (MH0039) para 10; Q72 [Melanie Costas]

195   Dr David Rose, Dr Faye Shortland, Dr Paul Hurley et al (MH0007) para 10

196   Q36 [David Rose]; Rural Support, *Building Strong Farm Families* [accessed 18 November 2022]

197   Q36 [David Rose]; Department for Environment Food & Rural Affairs (MH0036)

198   Q104 [Dr McCann]

199   Q298 [Lord Benyon); Department for Environment Food & Rural Affairs (MH0036) paras 24–6

have encountered in this area.[200] The second report does include case studies though on accessible mental health support provided to people in rural and farming communities by the NHS in Dorset and Somerset and the charity Lincolnshire Rural Support Network.[201]

Better national planning, research and data

88. The 2019 *NHS Long Term Plan* (LTP) set healthcare priorities for the next ten years and mental health ambitions up to 2023/24 to be delivered under the *NHS Mental Health Implementation Plan* (MHIP) including:

- Spend at least £2.3 billion a year of ring-fenced funding on local mental health services by 2023/24 to support an extra two million people

- Provide 370,000 adults and older adults with severe mental illness with community-based physical and mental care by 2023/24

- Provide 345,000 more children and young people with access to NHS mental health services, or school or college-based Mental Health Support Teams

- Rollout suicide prevention in every local area, and

- Tackle health inequalities using "integrated, population-level health systems" to support local and personalised prevention and treatment.[202]

89. Under the MHIP, Sustainable Transformation Partnerships (STPs) and Integrated Care Systems (ICS) were required to develop five-year local Mental Health Plans for up to 2023/24, setting out how their services would improve care for patients and communities, and how they would manage finance, workforce and activity.[203] Local plans were to be quality-assured by NHSE and NHS Improvement[204] to ensure delivery of LTP and MHIP mental health ambitions, and STPs or ICS had to develop them by engaging local communities; the local public, voluntary and private sector; embedding plans in the STP/ICS with a lead mental health provider and Senior Responsible Officer; commissioning based on data about local health inequalities; and aligned to other LTP-workstreams such as children and young people.[205]

200   Department for Environment, Food and Rural Affairs, *Rural Proofing in England 2020 Delivering policy in a rural context* (March 2021) p42–3, *Delivering for Rural England – the second report on rural proofing* (September 2022) p28–9

201   Department for Environment, Food and Rural Affairs, *Delivering for Rural England – the second report on rural proofing* (September 2022) pp23–4

202   NHS England, *The NHS Long Term Plan* (January 2019); NHS England, *NHS Mental Health Implementation Plan 2019/20 – 2023/24* (July 2019) p3. NHSE is an executive non-departmental public body (NDPB) of DHSC and leads the NHS in England.

203   NHS England, *NHS Mental Health Implementation Plan 2019/20 – 2023/24* (July 2019) p8. From 2015–22, STPs covered 44 areas of England bringing together local NHS organisations and local authorities to develop long-term plans for local health and care, including mental health. STPs were replaced in July 2022 by 42 ICSs which are partnerships of providers and commissioners of NHS services across a geographical area who work with local authorities and other partners to plan health and care to meet local population needs. ICSs aim to integrate care across different organisations and settings, join-up hospital and community-based services, physical and mental health, and health and social care.

204   NHS Improvement was an NDPB that oversaw NHS foundation trusts and NHS trusts, and independent providers that provide NHS-funded care. It became part of NHSE in July 2022

205   NHS England, *NHS Mental Health Implementation Plan 2019/20 – 2023/24* (July 2019) p8

Evidence to support national planning

90.   However, we heard that evidence available to inform and support national planning may not be adequate to deliver rural proofed mental health services. Sara Hughes CEO of the think tank the CFMH said national planning under the LTP and MHIP regime does try to identify local communities' needs, but does "not really refer to rural populations clearly enough" for local planning "to really understand" their various needs.[206] She said effective planning needed to include rural communities and identify what mental health workforce is needed, instead of "just hoping for the best and that national plans will apply."[207] The CFMH said NHSE could update the LTP to encourage ICSs to 'rural-proof' mental health support, by adapting rural provision to "ensure equity of access, experience and outcome" and take account of inequalities, such as ensuring that access does not depend on private transport and is accessible for children and young people.[208] This suggests more detailed evidence is needed but Rachel Hutchings of the health think tank the Nuffield Trust, said it is difficult for the NHS to understand mental health outcomes in rural areas given existing data covers broad areas for rural and urban populations. She said more detailed local data are needed to develop a fuller picture and understanding.[209] However, Dr Tim Sanders for the RCGP told us, such a picture may not be available from the high level data collected by local Health and Wellbeing Boards to identify rural populations' needs.[210]

The views of NHS England and the Government

91.   We asked Claire Murdoch NHSE's National Director for Mental Health whether the NHS has an accurate picture of the rural population's mental health needs. She said NHSE published quarterly information on health outcomes, investment and access, from regional to ICS-level for local authority areas from extreme rurality to cities.[211] Also, that NHSE measure progress against the LTP and expects two million more people every year to get access to mental health services; but it would be another five years before parity is reached with physical health services, including in rural areas.[212] However, the Government's supplementary submission to this inquiry, provided jointly by DEFRA and DHSC, referred to a challenge in gaining access to data on rural mental health in a format that was "consistent and granular enough to generate useful insights."[213] The then Health Minister, Gillian Keegan MP, told us that DHSC collects mental health prevalence data via surveys that are not rural specific but that the Government's new 10-year *Mental health and wellbeing plan*, aimed to improve data collection and sharing to help plan, implement and monitor improvements in mental health and wellbeing.[214] DEFRA/DHSC's joint

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206   Qq24 and 5 [Sarah Hughes]; NHS England, *The NHS Long Term Plan* (January 2019); NHS England, *NHS Mental Health Implementation Plan 2019/20 – 2023/24* (July 2019). Note: Neither the LTP nor MHIP referred to rurality, although in the former states NHSE planned to develop a "standard model of delivery in smaller acute hospitals who serve rural populations." (p23)

207   Qq5 and 24 [Sarah Hughes]

208   Centre for Mental Health [MH0037] para 25

209   Q28 [Rachel Hutchings]

210   Q203 [Dr Tim Sanders]

211   Q263 [Claire Murdoch]

212   Q263 [Claire Murdoch]; HM Government, *No health without mental health* (February 2011) p2. Since 2011 the Government has been committed achieving 'parity of esteem' in mental and physical health.

213   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 1

214   Q294 [Gillian Keegan MP]; NHS Digital, *Adult Psychiatric Morbidity Surveys* and *Mental Health of Children and Young People Surveys*; Department of Health and Social Care, *Mental health and wellbeing plan: discussion paper* [all accessed 19 November 2022]

submission to this inquiry said that DEFRA was engaging with DHSC to ensure rural mental health is "reflected" in this new plan—with DEFRA having connected DHSC with key rural stakeholders for follow-up discussions on the related call for evidence. However, we noted that, currently, the only reference to a rural differentiation in the plan's discussion paper is to levels of severe mental illness being higher "in urban areas (compared to rural)."[215]

92. However, in October 2021, DEFRA published new research in its *Defining and Measuring Rural Wellbeing* report which found rural schoolchildren and people dealing with financial instability such as farming find it particularly difficult to access mental health services and support.[216] It has developed *Rural Wellbeing Framework* guidance to help policymakers "better integrate rural wellbeing considerations into policy development," which DEFRA and DHSC seem to be now "considering" how to disseminate to ICS decision-makers.[217]

93. Despite such work it is unclear what input DEFRA has made to DHSC and NHSE to ensure mental health services are rural proofed; but NHSE has claimed that DEFRA has been more engaged in "recent years" over the new *Mental health and wellbeing plan* and green social prescribing in rural areas.[218] We asked DEFRA what evidence there was that rural proofing policy has impacted on how mental health services are delivered in rural areas. The Department said that it regularly reviewed the available evidence on the quality and accessibility of mental health services in rural areas, but as they "are delivered locally, it is challenging to access such data in a format that is consistent and granular enough [for DEFRA] to generate useful insights".[219] This implies that DEFRA cannot make a fully effective contribution to rural mental health policies or priorities and this impression was strengthened by DEFRA Minister, Lord Benyon, when he told us "we look at health outcomes in the context of rural proofing but, by and large, those are the property of the Department of Health and Social Care."[220]

94. In January 2023, DHSC announced that rather than finalise a new 10-year *Mental health and wellbeing plan*, the consultation responses it had received for it would instead be used to develop a new *Major Conditions Strategy* for six health conditions that contribute to England's disease burden—combining commitments on mental health, alongside those on others, "into a single, powerful strategy". The stated aim is to set out what actions "the centre" (i.e., DHSC and NHSE) can take to ensure that ICSs and their organisations do address clusters of local disadvantage. There are no details however about how the new Strategy will take account of rural mental health. An interim report on the Strategy is due by summer 2023.[221]

215   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 1; Department of Health and Social Care, *Mental health and wellbeing plan: discussion paper*, see Annex B (Severe Mental Illness) [accessed 19 November 2022]

216   Department for Environment, Food and Rural Affairs, *Defining and Measuring Rural Wellbeing - RE0294*, (February 2022) p41

217   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 6

218   Q267 [Claire Murdoch]

219   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 4

220   Q299 [Lord Benyon]

221   Department of Health and Social Care, *Mental health and wellbeing plan: discussion paper and call for evidence* (January 2023); HC Deb, 24 January 2023 HCWS514 [Commons written ministerial statement]. It will cover, cancers; cardiovascular diseases, including stroke and diabetes; chronic respiratory diseases; dementia; mental ill-health; and musculoskeletal disorders.

95. **Although DEFRA is clearly responsible for working with the Department for Health and Social Care (DHSC) to ensure mental health policy and services are rural proofed, it is unclear what priority, resources and energy DEFRA has assigned to achieving impact in this area. The NHS Long Term Plan and Mental Health Implementation Plan, together, provide the national framework for ambitions on mental health but, again, it is unclear how far rural communities' mental health needs are being taken into account not least when, as DEFRA confirmed, it does not have adequate data in this area.**

96. **DEFRA has produced a welcome framework and associated guidance for rural proofing policy but, for instance, claimed close working with DHSC and NHSE over the new 10-year cross-government Mental health and wellbeing plan has not so far resulted in a single reference to rural priorities (rather the reverse). Furthermore, there is no indication yet that any consideration has been given to the effect of subsuming national mental health and well-being into the new holistic Major Conditions Strategy on the struggle of *rural* mental health for attention and appropriate prioritisation. The profile of rural mental health needs to rise much further for real progress to be made, with DEFRA taking a more active role alongside DHSC.**

We recommend:

a) *DEFRA and DHSC should establish a new joint rural mental health policy and delivery team to lead and improve on current "rural proofing" of health policy; and work with NHS England to set targets to measure and improve outcomes for rural mental health services and support rural health providers.*

b) *The new joint DEFRA/DHSC rural mental health team should also set up a national working group, drawing together a range of experts, to identify practical changes to support more effective rural prioritisation within mental health services provision.*

c) *The new joint DEFRA/DHSC rural mental health team should work with NHS Digital, to evaluate the availability of data and information on rural mental health services to start to address the gaps we have identified.*

d) *DEFRA should consult on how the Rural Wellbeing Framework will be used to measure rural communities' mental health.*

Improving local planning and commissioning to remove barriers to access

97. Under the *Health and Social Care Act 2012* Clinical Commissioning Groups (CCGs) had responsibility and received NHSE funding to plan and commission local health services. CCGs were replaced by ICSs in July 2022 under the *Health and Care Act 2022*, which comprise of an integrated care partnership (ICP) and board (ICB).[222] NHS Trusts are responsible for providing those commissioned 'secondary care' services, including the following mental health services: Child and Adolescent Mental Health Services (CAMHS); Community mental health services for adults with mental health problems

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222   NHS England, *Integrated care systems (ICSs)* [accessed 30 November 2022]. ICPs comprise local health and care services including the NHS, GPs, local authorities and voluntary and community sector, and plan how to deliver them to meet local population needs, considering quality and affordability.

in the community; the Improving Access to Psychological Therapies (IAPT) programme for mild to moderate mental health issues using talking therapies; and hospital inpatient services for people in crisis or with severe mental health problems.[223]

98. Much of the evidence we received highlighted concerns that NHS mental health services are often not easily accessible to rural communities. As the CRPR told us, such services tend to be based on a model designed for urban rather than rural population needs, with centralised services creating barriers to access.[224] Gloucestershire Rural Community Council (GRCC) on behalf of Action for Communities in Rural England, said this is because "mental health services are not being sufficiently rural proofed in the development or review stage", highlighting North Yorkshire where most statutory mental health services are "in reach" of the city of Bradford but 20–30 miles from some rural communities making it difficult for them to access.[225] One consequence, according to Melanie Costas of RMHM, as noted in chapter 2, is that if people "do not see services in their community, they believe that they are non-existent," engendering stoicism, self-reliance and people presenting only in crisis.[226] She said every service from planning through to delivery must be "held accountable" to ensure they are "rurally inclusive".[227]

99. The Nuffield Trust provided useful context on the NHS being "defined and perceived as a national service", when "in reality", some parts of England such as rural areas "face disproportionate problems in delivering care to the standards people expect". This makes it difficult for them to recruit staff, "with smaller, more distributed populations, fewer younger people and greater competition for the locum or agency staff relied on to deal with shortfalls". In this context, the Trust said specialist services like mental health tend to "be spread across a large area", making access more difficult for patients and staff. So, when services are located far from rural communities, people have to travel substantial distances to get to them with access depending on using a car or public transport.[228] However, we repeatedly heard a lack of rural public transport is a key barrier which is largely provided via bus services which tend to be less economically viable to run than in urban areas, involve a limited service which is costly to use, require multiple routes and long journey times.[229] Barbara Piranty of GRCC summed-up the dilemma that if people need to access mental health support up to "30 miles away" then "if you are on a low income, you have no access to a car and buses are infrequent, you have no chance"; and Melanie Costas said, "you might be able to get to an appointment but not be able to get home" again.[230]

100. Some NHS provision moved online during the pandemic and much remains in place, and the Nuffield Trust suggested more use of technology and remote care could address some of the challenges of providing rural communities with access to services.[231] However, it said they "are more likely to be digitally excluded" as broadband and internet provision in rural areas are often poor and a barrier to NHS organisations providing services in

223   NHS England, *Mental health* and *NHS provider directory* [accessed 30 November 2022]
224   Centre for Rural Policy Research (CRPR) University of Exeter (MH0029) para 23
225   Barbara Piranty, CEO, GRCC (Gloucestershire Rural Community Council) representing ACRE (Action with Communities in Rural England) (MH0038) para 7
226   Q52 [Melanie Costas]
227   Q72 [Melanie Costas]
228   Nuffield Trust (MH0035) paras 4–5; The National Rural Mental Health Forum [MH0022] paras 7–8
229   Qq52 and 56 [Barbara Piranty, Melanie Costas]; Q115 [James Russell]
230   Q61 [Barbara Piranty]; Q57 [Melanie Costas]
231   National Farmers' Union (MH0028) paras 33–4; Nuffield Trust (MH0035) paras 7–8

rural areas.[232] Barbara Piranty of GRCC also told us, it means "people are excluded either by lack of availability of broadband, or speed, and some people cannot afford to be online", or as they do not want to access mental health services remotely.[233]

101. Given the various barriers facing rural communities to accessing mental health services other approaches need to be considered. Barbara Piranty of GRCC and Melanie Costas of RMHM suggested GP practices should look at people's physical and mental health together rather than separately, and the voluntary and community sector should be "embedded" in NHS services with a triage system in each primary care network at community level, to spot the "early signs of mental health issues", with people referred onto a Social Prescriber who can highlight local support such as a peer support group or places they can go to discuss their mental health.[234] We were told that as voluntary and community-based services which support mental wellbeing are "experts in early intervention" they should be part of the formal mental health 'landscape' with the NHS backed-up by sustainable funding.[235]

102. Sarah Connery of LPNFT told us the Trust is using a "hub and spoke" model to deliver mental health services in Lincolnshire, with teams based in communities so they are not "urban-centric" and to avoid exacerbating health inequalities.[236] She said community mental health transformation is an area the Trust has been able to plan for effectively as it is a "very firm strand" of the LTP which is not rural-specific but is about "making services more accessible for communities".[237] So the Trust is working to provide a service dedicated to rural communities' needs, integrating general practice with social prescribers to "connect people" to community assets like walking groups, allotments and connecting with nature. She said that setting up such groups had needed extra funding under the MHIP but secondary care caseloads were falling with people supported in their communities.[238] Going forward, she said planning services involves investing money in work the voluntary sector has the skills to do, to ensure they have "resource dedicated to prevention" to help stop people "going into crisis", as much as secondary mental health services.[239]

Services for children and young people

103. Rural isolation is a key issue for children and young people's mental health. The Care Quality Commission's 2018 review of England's mental health services for this age group found where they are located can make access difficult, especially if they live in rural areas and tend to face longer travel times to services. The Commission said this puts unnecessary barriers in the way to getting support if it is unaffordable to use local transport, and without access to support when needed, a young person's mental health might deteriorate so they may need more support later on.[240]

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232   Nuffield Trust (MH0035) para 8

233   Q52 [Barbara Piranty]

234   Qq62 and 66 [Melanie Costas]; Qq64 and 71 [Barbara Piranty]

235   Q71 [Barbara Piranty]

236   Q257 [Sarah Connery]

237   Q241 [Sarah Connery]

238   Q241 [Sarah Connery]

239   Q258 [Sarah Connery]

240   Care Quality Commission, *Are we listening? Review of children and young people's mental health services* (March 2018) p20

104. Mental health charities reflected these concerns in their evidence to our inquiry. Danny Hutchinson, of Invictus Wellbeing, said many young people in rural West Yorkshire often have to "travel 30 to 40 minutes for a session" with them, "which can be expensive, time-consuming and difficult for parents on low incomes".[241] Dan Mobbs of the charity MAP based in Norfolk told us a "lack of local services you can get to under your own steam" is a "critical issue" for young people in rural areas, as "even if your household does have a car you are entirely dependent on your parents to take you." But if public transport exists and "you are lucky enough to have a bus that goes from your village to where there is support, an appointment can take you all day", which can be very difficult for a young person especially if they are dealing with anxiety or depression.[242] Karen Black of the charity Off The Record which works in Bristol, South Gloucestershire and North Somerset, said proper thought and planning needs to go into where services are located, so they are somewhere young people want to go with good transport access, and are accessible for a diverse group of young people, "who might be struggling with identity, gender, sexuality", who may not see themselves reflected locally or in local service provision.[243]

105. Poor rural broadband and digital connectivity is another barrier to the accessibility of services. Danny Hutchinson told us many children and young people had "been pushed" into using digital resources and interventions, which they sometimes could not access due to limited broadband; but some did not want to, preferring instead "to be seen face to face" and "to speak to a person they can trust and know".[244] Dan Mobbs said it is important to give young people choice and not insist "you can only have digital access because you live in a rural area", as it may not always be appropriate or provide the privacy they need to access mental health support, for example if they share a bedroom.[245]

Responding to the farming community

106. In addition to physical transport and connectivity barriers, farming communities' access to mental health services is affected by occupational, cultural and service delivery issues. Some identified by the CRPR and research project led by Dr David Rose at Reading University were: feeling their work time is "precious" and lone working. Also, male farmers not seeking help until pushed to by female partners; stigma, pride and lack of understanding about mental health and support; inconvenient opening times and loss of faith in primary care because of past negative experiences or feeling "their farming situation would not be understood."[246]

107. The research project led Dr Rose highlighted a lack of join-up in delivery of mental health-support to farming communities, with many networks having been "created organically" by civil society groups. So, it may not always be clear to farmers where to go for help and they may not be "getting enough support from individuals who both understand farming and are trained mental health professionals."[247] The charity YANA, based in East Anglia and Worcestershire, said the farming community can find it difficult to get access to timely and affordable mental health support like counselling, because

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241   Q132 [Danny Hutchinson]

242   Qq76–9 [Dan Mobbs]

243   Q74 [Karen Black]

244   Q132 [Danny Hutchinson]

245   Q87 [Dan Mobbs]

246   Centre for Rural Policy Research (CRPR) University of Exeter (MH0029) paras 22–3; Dr David Rose, Dr Faye Shortland, Dr Paul Hurley et al (MH0007) para 12

247   Dr David Rose, Dr Faye Shortland, Dr Paul Hurley et al (MH0007) para 19

of long NHS waiting times or the cost of going private, so its free counselling service helps fills that gap.[248] YANA and the research project led by Dr Rose both said the NHS, local government and voluntary and community sectors need better coordination to improve support to the farming community; and the CRPR said mental health services in rural areas should be "co-designed and produced" by intended beneficiaries, in line with England's community mental health framework.[249]

108. Thought, therefore, needs to be given to how and where services are provided and who is trusted to help. The CRPR highlighted research that auction marts are "ideal venues" for primary care which farmers rarely access or have limited access to. It said by gaining visiting farmers' trust they may overcome "cultural and attitudinal barriers" by providing a service aimed at the farming community "in-situ" without need for an appointment. CRPR said some marts offer mental health and well-being services via Agricultural Chaplains or other farm organisations, but the few offering primary care are "widely used" and help many attendees' health and wellbeing.[250]

109. The central role that auction marts have in the life of parts of the farming community was highlighted by our witness Stephen Dodsworth who works as a Fields Person at Darlington Farmers Auction Mart in County Durham. He said he spoke to around 150 farmers each week and, though his "job is not to respond to mental health issues, he builds relationships with farmers by talking to them and "if a farmer is struggling" the mart "will notice a difference in perhaps their presentation of themselves or their livestock or just little things". He explained when farmers go to the mart "they are on home turf" but not if they go to a GP's surgery.[251]

110. Stephen Dodsworth suggested that the many livestock marts in northern England should work with farming mental health charities and bring them into marts to speak to the farming community "when they are comfortable".[252] It could be a form of early intervention and is what Farmerados does in Somerset. As Trudy Herniman explained, this volunteer group initially did Mental Health First Aid Training and wanted to raise awareness in the farming community so formed "pop-up living rooms" which they set up at livestock markets and agricultural shows, "turn[ing] up with tea and cake" and "just mix[ing] with people in their own environment" and talking to them and after a while they open up about how they are doing.[253] Another model the NHS could use in rural England is Northern Ireland's *Farm Families Health Checks* programme suggested by Jude McCann of the FCN. He explained it involved NHS nurses in a mobile unit going to every market and farm show in Northern Ireland, who "were mostly from farming families, so they could go out, stand outside the van and talk" about TB, the weather, prices, develop a relationship "and get farmers to come in to do physical health checks", and answer questions about mental health and wellbeing.[254]

111. The research project led by Dr Rose said measures to support farming mental health needed to include the "wide range of people" that families regularly "come into contact

248   YANA (MH0011) para 5
249   YANA (MH0011) para 8; Dr David Rose, Dr Faye Shortland, Dr Paul Hurley et al (MH0007) para 19; Centre for Rural Policy Research (CRPR) University of Exeter (MH0029) para 32
250   Centre for Rural Policy Research (CRPR) University of Exeter (MH0029) para 30
251   Q168 [Stephen Dodsworth]
252   Q168 [Stephen Dodsworth]
253   Qq168, 172 and 190 [Trudy Herniman]
254   Q101 [Dr McCann]

with". One support group told the project this could be vets or feed merchants but if it gets more serious they would turn to farming charities for help.[255] Many, such as RABI, provide confidential freephone helplines with counsellors who have a background or interest in farming and rural communities; FCN has volunteers who visit farms, and over time have been able to gain people's trust which encourages them to be open about their mental health. Charities like Farm Cornwall visit farms whose businesses may be struggling, which often relates to a mental health issue, and support them to find a way forward. The CRPR told us farming charities do "vital" work and "must be properly funded" long term.[256]

112. We asked rural health providers how they were providing services to meet the farming community's mental health needs and if it included outreach at farm shows or auction marts. Dr Jaspreet Phull, Acting Medical Director of LPFT, told us the Trust was engaging farmers' unions and farmers' networks, would appear at the Lincolnshire Show "to talk to farmers and agricultural workers", and were engaging agricultural chaplains as "access points" into the farming community "to signpost" mental health support. However, Dr Tim Sanders said such "outreach is a real challenge" for his GP-practice in Cumbria as it is not part of their NHS-contract, and they were having to focus on what they could actually deliver which was already difficult enough.[257]

Responding to the rural veterinary community

113. We heard the veterinary community also faced barriers to accessing NHS mental health support, as noted by James Russell of the BVA and Dr Rosie Allister of Vetlife. These include only being offered "restricted" appointment times which conflict with vets' long working hours and seasonally limited availability such as in lambing season. Also, the "very tough ask" vets face if they prioritise "their own mental wellbeing […] above the needs of being a vet on call", which can compound how they feel about themselves if they take time out to access NHS support.[258] If they do try to, some vets' mental health needs may get overlooked if they do not fit "specific" criteria "around diagnosis".[259]

114. Dr Allister told us Vetlife provides "extra mental healthcare" to people in the veterinary community with mental health conditions that "most people would expect" the NHS to respond to; but who "have not had their needs met", for reasons such as work patterns, expectations of work or the moral injury of having to decide to not work and leave no local veterinary care in place or take time off.[260] Dr Allister said the NHS needs to offer more flexible appointments so that people can attend them locally or further away, and "joined up physical and mental healthcare", citing evidence that most referrals to Vetlife cover physical and mental health issues often related to work so treating them separately "does not help".[261] She also said the NHS should provide support that takes account of a vet's "need to stay in work sometimes, [as they] might not have a choice about not working".[262]

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255   Dr David Rose, Dr Faye Shortland, Dr Paul Hurley et al (MH0007) para 10

256   Centre for Rural Policy Research (CRPR) University of Exeter (MH0029) para 33

257   Q260 [Dr Sanders]

258   Q114 [James Russell]

259   Q116 [Dr Allister]

260   Q116 [Dr Allister]

261   Q124 [Dr Allister]

262   Q124 [Dr Allister]

115. **The solution to providing accessible rural mental health services is unlikely to be "one thing" but more likely a package involving innovation and imagination from both patients and service providers.** *The new joint DEFRA/DHSC rural mental health team should consider how best to prepare and make an effective and integrated interventions with (i) the Department of Transport, and (ii) the new Department of Science, Innovation and Technology, in respect of achieving improved levels of accessibility to rural mental health services from new joined-up working, starting with the emerging rural transport strategy and Project Gigabit for rural broadband.*

Addressing stigma in service provision

116. We heard that mental health stigma is a key barrier to rural communities seeking NHS support.[263] Samaritans recently surveyed men living in rural areas, finding two-thirds cited stigma as a key reason not to seek mental health support; many respondents cited it as a barrier for the farming and rural veterinary communities.[264] Stigma is also an issue for children, young people and their parents who may not know where to get support for them; and for children struggling with their identity, gender or sexuality, who do not see themselves reflected in the local population or service provision.[265]

117. Respondents such as the British Association of Counselling and Psychotherapy said "conversations around mental health" need to be normalised "to help reduce stigma as a barrier to help-seeking behaviour.[266] Such work is being done by RMHM in Dorset through its Wellbeing Wednesdays in libraries, which provides "outreach" in a safe, accessible and welcoming place where you can talk to someone.[267] Mobile outreach is done by the Farmerados and FCN; and Rural Coffee Caravans, which Alicia Chivers of RABI said make it "non-threatening" to discuss your physical or mental health, suggesting the model be considered by local NHS commissioning.[268] In Lincolnshire we heard LPNFT is engaging farmers' unions and farmers' networks about mental health to facilitate discussions with farmers and agricultural workers about mental health.[269] RABI has developed training to give farming peer support groups and volunteers "skills to help normalise" conversations about mental health and wellbeing; and RMHM has called for free government-funded Mental Health Awareness training for people in rural communities to reduce stigma.[270] The then Health Minister, Gillian Keegan MP, said DHSC would be looking at how to reduce stigma in reviewing responses to its call for evidence for the new 10-year *Mental health and wellbeing plan*.[271] As noted above however, DHSC announced in January 2023 that responses to its consultation will be diverted to help develop a Major Conditions Strategy.[272]

263   The National Rural Mental Health Forum [MH0022] para 13

264   Q215 [Jacqui Morrissey]; The Countryside Alliance (MH0031) paras 14,18, 29; Q113 (Dr Allister)

265   Q74 [Karen Black]

266   British Association for Counselling and Psychotherapy (BACP) (MH0021) para 27

267   Qq65–7 [Melanie Costas]

268   Q92 [Dr McCann]; Qq168, 172 and 190 [Trudy Herniman]; Q100 [Alicia Chivers]

269   Q260 [Dr Phull]

270   Q95 [Alicia Chivers]; Royal Agricultural Benevolent Association, *RABI responds to poor farmer wellbeing with new services in 2022* (January 2022); Rural Mental Health Matters (MH0039) para 12

271   Q267 [Claire Murdoch]; Q268 [Samantha Allen]; Q321 [Gillian Keegan MP]

272   Department of Health and Social Care, *Mental health and wellbeing plan: discussion paper and call for evidence* (January 2023); HC Deb, 24 January 2023 HCWS514 [Commons written ministerial statement]

The new model of Integrated Care Systems

118. We heard views that the new ICS-model could lead to more join-up in NHS provision as well as questions about the evidence for decisions on population need. Sarah Hughes of the CFMH was optimistic that ICSs will be able to pool budgets and work much more closely to deal with some of the challenges of planning services in rural areas; but wanted rural communities needs to be "really highlighted" and prioritised in local ICS-planning as they are the "immediate levers" for improving people's experiences.[273] However, Sarah Connery of LPFT said there was still a lot of work to do for secondary mental health, other NHS providers and the voluntary sector to make "meaningful connections" between the data they collect and local planning and commissioning decisions and providing their rural population with access to mental health services.[274] Dr Phull, LPFT's Acting Medical Director, said the Trust was looking to develop a centre for rural and coastal mental health to help it "get the right evidence-based interventions".[275] For the RCGP, Dr Tim Sanders said the primary care sector is concerned its "voice" could be "diminished" in the ICS-model and wants to ensure it can continue to "feed" its detailed knowledge of local need into commissioning decisions.[276]

119. Claire Murdoch of NHSE told us ICSs will improve mental healthcare for rural people under the "national framework" set by NHSE, as it gives much "stronger accountability" with each ICS having to show it is tackling inequality and involving local people and local partners in developing and delivering health priorities. As each area is different though she said each ICS has to work out how to address health inequalities, citing Somerset NHS Foundation Trust's nurse-led clinics in places like livestock markets for the farming community.[277] Samantha Allen, CEO of the North-East and North Cumbria ICB said ICSs need models to "fit" local rural, coastal and urban communities, and to show they are "improving outcomes", but also time and support to lead locally and "not be overburdened by central directives", but a revised MHIP would be useful which they could "adapt" to local need.[278] We asked the then Health Minister, Gillian Keegan MP, how the Government will ensure rural mental health services give fair access to rural communities. She said ICSs must "use all the tools" they have to work with local authorities, both have a statutory duty to co-operate, and DHSC will monitor what ICPs are doing. She said ICPs need to ensure that voluntary and community sector services which rural communities rely on areas are "formally" included and "commissioned to give them sustainability where [it] makes sense". She also looks for best practice for local areas to consider and apply if they work locally.[279]

120. **We conclude that NHS mental health services are often not fairly accessible for rural communities, with centralised services creating barriers to access, compounded by poor rural transport and weak digital connectivity.**

121. *Locally the NHS must focus on providing rural communities with good access to services in terms of location and/or via mobile or outreach services, through effective*

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273   Qq29 and 50 [Sarah Hughes]
274   Q241 [Sarah Connery]
275   Q239 [Dr Phull]
276   Q243 [Dr Sanders]
277   Q269–72 [Claire Murdoch]
278   Q273 [Samantha Allen]
279   Q301 [Gillian Keegan MP]

consultation and co-design, and bring the voluntary and community sector into the delivery landscape given its expertise in early intervention as trusted providers. It should put effort into reducing the stigma of mental health to support help-seeking behaviours.

122. *The NHS also needs to open-up access to the rural veterinary community to reflect restrictions on their ability to attend appointments, and support people who need to continue practising. Better digital provision could improve service access but must not be the default offer to rural communities, as it is not always appropriate or suitable.*

123. **We believe Integrated Care Systems (ICS) will be crucial to determining whether NHS mental health services are able to respond better in future to rural communities' needs.**

124. *We recommend the joint rural mental health policy and delivery team issue a call for evidence on the effectiveness of the ICS-model for providing rural communities with access to mental health services and publish its findings with proposals to address any shortcomings, by the end of March 2024. The team should work with rural ICSs, health providers, and charities, to identify cost-effective care pathways to increase provision and remove barriers to NHS treatment for agricultural and veterinary workers, by increasing flexibility in appointments times, options for care, and location of services including outreach at auction marts.*

Preventative support for children and young people's mental health

125. In terms of children and young people's mental health in rural areas, the evidence we received highlights that the NHS needs to put more effort and resources into prevention rather than just providing reactive services to patients in crisis. Mental health charities working with this age group in rural areas told us too much reliance is put on CAMHS for which there can be very long waiting times as the Service finds it difficult to recruit and retain staff.[280] Dan Mobbs CEO of MAP said:

> CAMHS […] are doing a lot of heavy lifting for the youth sector. There is this idea that everybody needs to go to CAMHS, but that is not true; it is just that it is all that remains […] If they are the only show in town to support young people with their mental health, they are never going to meet those needs and nor are they the right places and people to meet those needs.[281]

Karen Black, CEO of Off The Record, told us CAMHS was under a "huge amount of pressure" because of their structure and work, and high demands arose due to the expectation of being able to refer patients as there is very often nowhere else to "signpost" young people towards in a rural area.[282]

126. We heard a lack of alternative provision is mainly due to a lack of funding and reduced provision for youth services over the last decade across England.[283] Danny Hutchinson CEO of the charity Invictus Wellbeing told us cuts in funding for youth services had "impacted where children and young people can go to if they have a problem" and need to

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280   Q80 [Dan Mobbs, Karen Black]
281   Q80 [Dan Mobbs]
282   Q80 [Karen Black]
283   Q76 [Dan Mobbs]; Q132 [Danny Hutchinson]; Centre for Mental Health [MH0037] para 16

speak to someone or a professional and this had especially affected rural communities.[284] Whilst Karen Black said a lack of rural youth services, "leads to young people presenting to services because they are in crisis" as "nothing has come before that", so the problems they see "are often much worse".[285] A lack of rural social infrastructure may also be due to rural charities being smaller and having less capacity and expertise to fundraise, build infrastructure or hold risk, compared to urban charities.[286] An over-reliance on CAMHS was also highlighted by Sarah Connery CEO of LPNFT who said in Lincolnshire, secondary mental healthcare services are relied on for children and adults, as other "rural community assets" do not exist.[287]

Investing in prevention

127. Instead of 'reactive' mental health services, we heard a strong case for responding to the wider circumstances affecting children and young people's mental health. Karen Black of Off The Record told us:

> If we constantly talk about young people responding to mental health [services], we are never going to do anything differently [… or] change the long-term outcomes for them. We need to be thinking about all the infrastructure and all the challenges young people face and that is about youth provision meaning they have access to role models if they have domestic violence, poor housing, worklessness, alcoholism, drug use and so on."[288]

She said a discussion was needed with Government departments about the circumstances affecting children and young people's mental health; otherwise the "conversation" will just continue to be about "what we should do about mental health", as "we are always going to prioritise the money going into crisis […] because those young people are in the greatest distress, but they are always going to be in distress if we do not stop it somewhere over here."[289]

128. We heard many young people referred to CAMHS actually need to access youth services offering prevention support through groups, activities and mentoring.[290] Danny Hutchinson of Invictus Wellbeing explained it involves focusing on "protective factors" which are "a sense of belonging, a sense of community, being part of something, feeling like they have self-worth, self-belief, confidence, self-esteem.[291] This reflects CQC's 2018 review of mental health support for children which concluded that services offering "prevention, early intervention and promotion of good mental health are vitally important for children and young people". Without this, the Commission said CAMHS' waiting lists would continue to rise, so early intervention gets "side-lined" because waiting times need to be urgently addressed and soak up the resources. However, poor accessibility, and long waiting times, at CAMHS leads to children and young people seeking help from local charities, who find they are "working with children with increasingly severe mental health

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284   Q132 [Danny Hutchinson]
285   Q74 [Karen Black]
286   Q80 [Karen Black]
287   Q241 [Sarah Connery]
288   Q79 [Karen Black]
289   Q79 [Karen Black]
290   Qq80 and 87 [Dan Mobbs], Q80 [Karen Black], Q134 [Danny Hutchinson]
291   Q134 [Danny Hutchinson]

needs".[292] But we also heard that rural youth facilities and other social infrastructure are often lacking, creating a vacuum and a missing first step in the ladder of children's well-being (other than school).[293] Karen Black, of Off The Record, said youth services needed more investment, to provide "wider support structures" so that mental health charities can be "… part of the puzzle rather than the solution".[294] The Children and Young People's Mental Health Coalition said that 'early support hubs' would offer "open access, flexible, early support for young people under 25 in their communities", without the need for a referral or appointment to get mental health advice and support before reaching crisis.[295]

Mental Health Support Teams

129. Mental Health Support Teams (MHSTs) provide early intervention support in England's schools and colleges, and by 2024 there should be over 500, contributing to the LTP's ambition of 345,000 more children and young people accessing NHS-funded mental health services by 2023/24.[296] On the efficacy of MHSTs in rural schools, Danny Hutchinson, Invictus Wellbeing, told us a local MHST in West Yorkshire was effective in co-ordinating voluntary and community sector support but is "probably still not enough".[297] Karen Black said a new MHST run by Off The Record in North Somerset schools was "welcomed" as schools see themselves as "wraparounds", and schools' messaging about mental had been "very successful", but "generational messaging around stigma, isolation and understanding" in small rural communities needed addressing.[298] Dan Mobbs of MAP told us schools were under "a lot of pressure" to do many different things which they may not have expertise in and can sometimes be "very challenging for young people to access support through", so schools need access to specialists "and training them and not expecting the history teacher to suddenly be an expert in mental health and wellbeing".[299]

130. Sarah Connery CEO of LPFT said the Trust had been working with the local authority and schools to provide mental health support, training and awareness, but there was not enough funding to "roll it out to all schools".[300] The GP Dr Tim Sanders, based in Cumbria, told us more support staff in schools had "made a big difference" to their ability to respond to children's mental health needs.[301] He said it required a dialogue to ensure schools understood "what is useful and valuable to bring the system together around the child"; and although MHST-referrals give a fuller picture of children's educational outcomes, the system still needed to be more joined-up so that medical and teaching professionals fully understand referral routes, and "who the best practitioner is" to make them.[302]

131. We asked Claire Murdoch of NHSE about the over-reliance on CAMHS in rural areas. She said the CAMHS "treatment gap" needs tackling so children and young people can get specialist care when needed; but "the NHS cannot do it on its own" and she said

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292   Centre for Mental Health [MH0037] para 15, citing from Care Quality Commission, *Are we listening? Review of children and young people's mental health services* (March 2018)
293   Qq80 and 87 [Dan Mobbs], Q80 [Karen Black], Q134 [Danny Hutchinson]; Centre for Mental Health [MH0037] para 16
294   Q86 [Karen Black]
295   Centre for Mental Health [MH0037] para 25; Q82 [Dan Mobbs]; Qq149 and 167 [Danny Hutchinson]
296   NHS England, *Mental health support in schools and colleges* [accessed 28 November 2022]
297   Q165 [Danny Hutchinson]
298   Q84 [Karen Black]
299   Q83 [Dan Mobbs]
300   Q241 [Sarah Connery]
301   Q258 [Dr Sanders]
302   Qq258–59 [Dr Sanders]

that NHSE supported the idea of "youth hubs" which stakeholders have called for.[303] She was concerned a reduction in youth services and social infrastructure may "drive a crisis model of care in which we wait until the point where a youngster is self-harming and arrives at A&E"; and had raised "prevention, early intervention and social infrastructure" for children and young people in meetings at No.10 and other national forums.[304] She said 40% of schools would have MHSTs by 2023/24, exceeding the LTP's 35% target, and 2,000 therapists had been trained to work in them giving "fast access to CAMHS".[305] We put it to Claire Murdoch that not all schools had "fast access" and many parents cannot get an initial assessment or appointment for CAMHS for their children or even if they are in crisis. She acknowledged the "outrage" that NHSE's modelling found just a quarter of children or young people could get access to CAMHS at the start of the LTP in 2019. She said the LTP aims "to close the treatment gap" and MHSTs were still being rolled out, but "170,000 more children and young people" were seen in 2021/22 against the previous year, the CAMHS workforce grew 40%, must grow another 40%, 100% of schools need MHSTs and NHSE must plan for the next five years.[306]

132. We asked the then Health Minister, Gillian Keegan MP, about the length of waiting times for CAMHS and how she would address them. She acknowledged "pressure" on CAMHS as demand "quadrupled" due to more "eating disorders" amongst young people during the pandemic, and said that the Government was investing more than ever in mental health under the LTP, to grow the CAMHS workforce and shift to prevention with MHSTs.[307] She also told us that the Government recognised departments could work more closely together and had been doing so on the cross-departmental 10-year mental health and wellbeing plan, with the Department for Digital, Culture, Media & Sport (DCMS) leading on youth services.[308]

133. **Child and Adolescent Mental Health Services (CAMHS) have been under intense pressure for many years, but a lack of alternative rural social infrastructure and a fall in support for youth services means CAMHS is often the "only show in town". However, focussing on providing 'reactive' mental health services will only go so far, especially given CAMHS waiting times, so the focus and resources need to shift to prevention. Early intervention via Mental Health Support Teams (MSHTs) is a positive development but needs to be rolled-out to all rural schools as soon as possible and adequately resourced with appropriately trained staff given the many responsibilities on schools. Youth service provision in rural areas also needs to be expanded but until that is delivered, whilst demand is high on CAMHS, and alongside MHSTs, much more investment is needed in other forms of prevention such as 'Early Support Hubs'.** *Therefore, we recommend that DHSC, NHS England and DEFRA consult on proposals to reduce reliance on CAMHS by expanding preventative mental health support for children and young people by, (a) setting out a path to expand provision of MHSTs to 100% of schools and colleges in rural areas by 2026/27, and (b) committing to establish and fund 'Early Support Hubs' that can be accessed by children and young people in rural areas by 2024/25.*

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303   Q274 [Claire Murdoch]
304   Q274 [Claire Murdoch]
305   Q275 [Claire Murdoch]
306   Qq277–78 [Claire Murdoch]
307   Qq296–7 and 307 [Gillian Keegan MP]
308   Q308 [Gillian Keegan MP]

Training to improve support for agricultural and veterinary workers

134. During our inquiry we heard the NHS does not always appear to understand the context, pressure and demands on the farming and veterinary communities. RABI's CEO, Alicia Chivers, cited anecdotal evidence from that its counselling service had advised callers to go to their GP, only for a GP to advise a patient "to take a couple of weeks off on holiday". She also said if NHS-staff receive training it is not "reinforced" that "stock solutions" for the rest of the population "are not appropriate" for the farming community.[309] The CRPR highlighted research indicating "it is essential" that the farming community "feel that farming-specific issues and circumstances will be understood by those they are seeking help from." Rural GPs, Community Psychiatric Nurses and other health workers need to receive information and training about the challenges facing the farming community.[310] YANA acknowledged the "strain" on the NHS but said it needs to "demonstrate empathy and authentic understanding" of the farming community and invest "resources to raise awareness and provide support" for mental health.[311] It said charities like itself and the DPJ Foundation in Wales fill a "gap" in "understanding" as they are "perceived as credible and able to relate" to the sector's challenges.[312] YANA suggested Op Courage, the NHS mental health service for current or former members of the Armed Forces, as a role model, due to Op Courage's specialist knowledge of its client group and the support needed.[313]

135. A lack of NHS understanding about veterinary workers seems apparent in the lack of flexibility in appointments and treatment vets are commonly offered.[314] A need to improve health professionals' knowledge of the challenges facing the veterinary community should perhaps be apparent given their work and caring role alongside farmers including during animal disease outbreaks.[315] Research looking into the service run by Vetlife found that "service users valued the veterinary-specific knowledge" of Vetlife's clinicians and that "such services may help to navigate a pathway to effective care, through the NHS or privately", indicating the NHS could enhance its understanding of this occupational group by working with such service providers.[316]

136. **It is very important for the farming and veterinary communities to feel that their circumstances are understood by NHS staff when seeking to access, or receiving, support (otherwise this may work against help-seeking behaviours). Charities with specialist-knowledge can gain people's trust from a position of credibility, so it makes sense to engage them to boost NHS staff understanding and/or to develop occupationally specific mental health initiatives, to provide a model for the NHS to improve support for farming and veterinary mental health.** *We recommend that DHSC and DEFRA identify farming and veterinary mental health as high priorities for action and by September 2023, develop a work programme with NHS England, public health and agricultural and veterinary charities to identify measures and targets to improve mental health outcomes for these occupational groups; and that DHSC mandate Health*

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309   Q100 [Alicia Chivers]

310   Centre for Rural Policy Research (CRPR) University of Exeter (MH0029) para 25

311   YANA (MH0011) para 7.1

312   YANA (MH0011) para 2.1

313   YANA (MH0011) para 7.1

314   Q114 [James Russell]; Q124 [Dr Allister]

315   Qq109–10 [Dr Allister, James Russell]; Bovine Tuberculosis Partnership for England [MH0030] paras 7–10

316   A. McKenzie, R. Allister, D. Humphrey, K. Moore, K. Greenberg and N. Greenberg, *An evaluation of a veterinary-specific mental health service*, *Occupational Medicine*, Vol 70, Issue 3 (February 2020) p2

Education England to work with agricultural and veterinary charities to develop a training programme for rural NHS providers and staff to be launched by Autumn 2023, about these occupational groups' mental health needs to improve their care.

Ensuring fair funding

UK and local government spending on mental health

137. In 2020/21, CCGs spent around £9.5 billion on mental health, about 10% of the total funding allocated to them for health services. NHSE spend a further £2.2 billion on specialised commissioning for mental health services.[317] In 2021/22, DHSC committed an extra £500 million under the Mental Health Recovery Action Plan to reduce waiting times for mental health services, including in rural areas.[318] As noted earlier, the Government also committed to increase spending on mental health services by "at least £2.3 billion a year by 2023/24" under the NHS Long Term Plan (LTP). This expenditure is via the Mental Health Investment Standard (MHIS) introduced in 2015/16, whereby CCGs are expected to increase local mental health spending by "at least as large, proportionally speaking, as overall increases in local health funding". This reflects the Government's aim, since 2011, to try and achieve 'parity of esteem' in mental and physical health.[319]

138. Despite the MHIS mechanism, we heard that NHSE's funding allocation system may disadvantage rural and remote areas after all because it does not compensate them for the additional costs they carry, which may affect quality and access to healthcare. The Nuffield Trust told us that areas such as these "can face unavoidably higher costs in providing healthcare". These include difficulties in staff recruitment and retention and higher overall staff costs; higher staff travel costs and less productive staff time; as well as the scale of fixed costs to provide services which creates difficulties in realising economies of scale whilst serving sparsely populated areas.[320] The Trust's research indicates the MHIS system includes adjustments for factors affecting a local population's needs for services and the costs of delivering them; taking account of rural areas' higher levels of health need (largely due to their older populations); and the extra costs of ambulance provision and a remoteness allowance. However, the Nuffield Trust suggests these factors are "hugely outweighed" by factors that still move funds to urban areas, including adjustments for market forces, such as the higher costs of land, buildings and labour, and health inequalities. Also, allocations that take account of additional rural costs like ambulance services, and some small rural trusts with larger A&E facilities, "do not benefit mental health services".[321]

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317   *Mental health statistics (England)*, House of Commons Library, December 2021, p39. According to the Library, "figures for mental health spend by CCG alone – independently of learning disability and dementia services – are not published." We estimate £9.5 billion was spent by CCGs on mental health in 2020/21, is based on deducting £2.6 billion spent on dementia or learning disability services from the overall figure of £12.1 billion spent on these services plus mental health in England.

318   Department for Environment Food & Rural Affairs (MH0036) paras 21–22; Department of Health and Social Care, *Mental health recovery plan backed by £500 million* (March 2021). The latter "aims to respond to the impact of the pandemic on the mental health of the public."

319   Department for Environment Food & Rural Affairs (MH0036) paras 21–22; NHS England, *NHS mental health dashboard* (accessed 16 November 2022); *Mental health statistics (England)*, House of Commons Library, December 2021, pp39–40; HM Government, *No health without mental health* (February 2011) p2

320   Nuffield Trust (MH0035) para 9

321   Nuffield Trust (MH0035) paras 4 and 14; Nuffield Trust *Rural and remote health services lose out on NHS funding* (January 2019) [accessed 15 November 2022]

139. The Nuffield Trust told us the current funding system transfers "significant sums" from rural to urban areas", including a "'pace of change' adjustment", to cushion changes to avoid disruption for areas where the formula reduces funding (with the likelihood that the new arrangements, for example, allocated 15% more funding to West London in 2019–20 "than its fair share". The Trust stressed that, "if insufficient adjustment or compensation is made" for the higher costs incurred in rural areas in providing healthcare, then "affected health services may not be able to provide their populations with the same access to, and quality of, care that others do".[322] Rachel Hutchings from the Trust said it is unclear if the adjustment fully accounts for extra costs in providing care in rural areas in general, rather than mental health, suggesting work is needed "to interrogate" this and the situation since ICSs took over in July 2022.[323]

140. We asked representatives of the NHS in rural areas, from secondary and primary care and an ICS, whether they face additional delivery costs in running services, including mental health, and if it is accounted for by NHS funding. Sarah Connery, CEO of LPNFT, reiterated many of the Nuffield Trust's points about higher costs in providing healthcare regarding staff recruitment and retention, higher staff costs, higher travel costs and less productive staff time, and limited scope for economies of scale. She said the Trust "cannot be everywhere" as it cannot recruit the staff, so it is a "challenge" in terms of "quality, cost and accessibility" and having a "good quality, sustainable workforce" which "does not involve service users having to drive for an hour or change on three buses to access that service".[324] She said it had needed to close wards as it had not always been able to recruit enough medical staff to run them safely, but this had enabled it to innovate with alternative models of care.[325] She was not "aware that the [NHS] funding allocation [system] takes any account" of the differences in delivery costs for rural areas and called for more evidence to fully understand the issue.[326]

141. Dr Tim Sanders contrasted healthcare in the London Borough of Lambeth with north Cumbria which both serve around 325,000 people, but he did not think central funding ensures rural areas such as this receive an appropriate level of healthcare resources, as it does not take "into account that you cannot run services from single sites in a sparsely populated area in the same way that you probably can in a densely populated metropolitan area". Also, the multiple sites providing services are necessarily going to be smaller reducing their resilience and ability to stay open if staff are off sick or there are persistent vacancies. Dr Sanders also said that smaller individual sites also prevented the sort of an operational "critical mass" needed to create "centres of academic excellence" to, in turn, attract candidates to fill vacancies.[327] Samantha Allen told us the Board received its funding "based on a weighted formula" and "population needs", but acknowledged the Nuffield Trust's evidence and "the challenge" of sustainability and costs of providing rural healthcare". She said the ICB responds by absorbing costs locally in how it uses its funding and makes funding decisions. She described one of its most rural areas having

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322   Nuffield Trust (MH0035) paras 10, 12 and 13
323   Q31 [Rachel Hutchings]
324   Q250 [Sarah Connery]
325   Q250–51 [Sarah Connery]
326   Q253 [Sarah Connery]
327   Q253 [Dr Sanders]

two main hospital sites, 40 miles apart, which is a "cost" to the NHS and local population in terms of inequality, transport and access to services. She said the ICB was working to better understand the situation to support rural providers.[328]

142. The then Health Minister, Gillian Keegan MP, told us she disagreed with the Nuffield Trust, as it was "judgement" rather than evidence-based, reflecting a "disagreement" on how the funding was calculated.[329] DEFRA and DHSC's supplementary submission said NHSE's system for allocating funding to ICBs is based on the principles, "of ensuring equal opportunity of access for equal need, and NHSE's duty to have regard to the need to reduce inequalities in access and outcomes". It said these are reflected in the funding formula, "which produces a target allocation or 'fair share' for each area, based on a complex assessment of factors such as demography, morbidity, deprivation, and the unavoidable cost of providing services in different areas".[330] On mental health services, the Departments' said the system "reflects higher need related to rurality" by including "need and supply variables", respectively being "difficulty of access due to distance" and typical rural characteristics such as age.[331] However, DEFRA/ DHSC made clear responsibility lies, ultimately, at the local level, as the allocation system distributes funding to ICBs, but "it is ICBs' responsibility to allocate resources to places and to different services within their system […] as they best understand their local geographies and population".[332] As Chapter 2 highlighted, DEFRA Minister Lord Benyon acknowledged the IMD's shortcomings which is important to capture a fuller picture of rural deprivation and told us DEFRA is working with DLUHC and other Departments to address this.[333]

143. **We welcome the Government's commitment to provide more funding for mental health and to ensure local mental health spending increases by the same proportion as overall increases in local health funding. Despite this, we are concerned by the possibility that the system used by NHS England to allocate funding fundamentally disadvantages rural areas. The Government's settled view is that the system is fair and balances a range of complex criteria. We consider more work to be needed to ensure that appropriate resources fully respond to rural communities' mental health needs and reflect the additional costs that rural areas must carry as, if this is not the case, rural communities will remain disadvantaged. We are pleased the Government is working to address shortcomings in how rural deprivation is measured.** *However, we ask the Department to provide us with a detailed statement of the process and the formula, in reply to this report, upon which to seek assurances from an independent source such as the National Audit Office.*

144. *We recommend that DEFRA and the Department for Levelling Up, Housing and Communities set out a timeline and process by which to review and revise the Index of Multiple Deprivation with the aim of more accurately capturing rural deprivation.*

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328   Q282 [Samantha Allen]

329   Q310 [Gillian Keegan MP]

330   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) paras 21–4

331   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 26

332   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) paras 27–8

333   Q311 [Lord Benyon]

The Government should commit to reaching a position by the end of this year, 2023, whereby it can commence a consultation on draft changes to the Index and guidance for decision-makers, and how the Index should be used to support funding decisions.

Responding to crisis events

145. As we have discussed, crisis or "shock" events can be very detrimental for the mental health of the farmers, and the vets, involved. Animal disease outbreaks such as bTB or Avian Influenza cause great distress to the farming community due to the risk to livestock, as restrictions are imposed, not knowing how long they will last, financial uncertainty and the inevitable distress of animal culling.[334] Chapter 2 noted the management of outbreaks can be a source of anxiety and undermine farmers' trust in disease control measures, and such crises can negatively affect veterinary workers' mental health given their supportive and possibly, caring, role to farmers in such situations.[335] There can be long-term impacts as with the 2001 Foot and Mouth Disease (FMD) outbreak which charities, researchers, the NHS and Government, said was still affecting the farming community and veterinary workers involved in the crisis.[336] There is established evidence that FMD and other crises involving animal culling "cause a lot of trauma" which may lead to an increase in the risk of anxiety, depression, post-traumatic stress disorder (PTSD) or suicide.[337] Other crises such as flooding, droughts and fires can also affect people's mental health. For example, flooding events are more likely to lead to an increase in GP and hospital visits and self-reporting of mental distress, higher levels of anxiety, depression and PTSD.[338]

146. Some of our witnesses said the NHS provides limited support for rural communities' mental health during and after crises. Dr Kreseda Smith, Harper Adams University, pointed out that there was "short term" support for "unanticipated shocks" like flooding, but not regularly occurring events like herd culls because of bTB or crop failure.[339] Rural Action Derbyshire was not aware of mental health support after shock events in rural communities other than that being given by local and national charities.[340] The NFU contrasted NHS-guidance that early intervention after major incidents helps reduce people's distress after major incidents with NFU-members' feedback that "targeted support does not extend beyond the initial incident response stage and ongoing support is not readily available." The NFU suggested scope exists "to develop a major incident support pathway" to provide "an adequate response" to farmers after crises, or ensure it is well-known such a pathway already exists.[341]

Local and national health planning for crisis events

147. Health providers told us limited local planning takes place for mental health impacts from animal disease outbreaks or floods. GP Dr Tim Sanders said his practice in Cumbria

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334   Q89 [Alicia Chivers]; Q175 [Edward Richardson]; Q110 and 122 [James Russell]; Q123 [Dr Allister]; Q93 [Dr McCann]

335   Q111 [James Russell and Dr Allister]; Bovine Tuberculosis Partnership for England [MH0030] paras 7–10

336   Q43 [Dr David Rose]; Q179 [Trudy Herniman, Melinda Raker]; Q281 [Samantha Allen]; Q317 [Lord Benyon]; Q111 [Dr Allister]. The outbreak lasted from February to September 2001 during which over six million sheep, cattle and pigs were culled, BBC News, *When foot-and-mouth disease stopped the UK in its tracks* (17 February 2016)

337   Q248 [Dr Phull]

338   Q43 [Sarah Hughes]; Centre for Mental Health (MH37) paras 20–21

339   Dr Kreseda Smith (MH0005) para 15

340   Rural Action Derbyshire [MH0006] para 11

341   National Farmers' Union (MH0028) paras 27–9

responds, "by doing what any close-knit community does and we try to pull together", but often it is "only after the waters have receded and the silt has been washed away that people draw breath, and it is at that point when they need a lot of support". He said, more support is needed for crises but no extra resource was available, and the community and GP-practice responds as best as they can through a difficult time.[342]

148. Dr Phull told us not enough planning or resource management has been done to develop responses to extreme weather events, animal disease outbreaks and culls. Healthcare and other institutional organisations respond in a "very ad hoc way" to crisis events by everyone rolling up their sleeves and getting on with it. Dr Phull said the Trust tries to "signpost" and work with partners to identify people at risk and increase access to mental health services, but also that no extra resources or funding becomes available as a matter of course.[343]

149. Since July 2022, ICPs and their Boards have been "category 1 responders" under the NHS Emergency Preparedness, Resilience and Response Framework.[344] Samantha Allen, CEO of the North East and North Cumbria ICB, explained it means ICBs "co-ordinate and work with [their] multi-agency partners to react to an event", and with partners via local resilience forums on how to prepare and later learning. She said the process provides an opportunity to consider high-risk occupations and impacts on individuals and communities and to feed learning into mental health and suicide prevention work, including past crisis responses and "legacy" and trauma such as from FMD in 2001.[345]

150. Claire Murdoch, NHSE's National Director for Mental Health, told us NHSE's role, was to provide national advice about any "clinical intervention", in terms of "what an immediate response should look like from a mental health point of view" and "what the response to trauma months and years later should look like, [and] when to intervene and when not". She said if a crisis affects a large area local authorities "lead and co-ordinate" a joined-up response and the NHS is "an important partner but not the sole provider".[346] On resources for crisis events, Claire Murdoch said the NHS "can flex its budget" to give extra resources to an area but funding is largely "already allocated" for the year. For local health funding for ICBs she said NHSE would always look at if it can provide additional resource to support mental health because of crises, so will liaise with DHSC who will speak to other departments, about "what additional funding is available" and any multi-agency plan.[347]

151. DEFRA's written evidence said the Government is committed to ensuring the right mental health support is "in place" for people affected by flooding and other crises.[348] Gillian Keegan MP, then Minister for Health, stressed the importance of making sure ICS and ICPs working together locally, to put in place services to support people around trauma and mental health, using "the tools" issued by the Government and adapting to local need.[349] These include: NHSE clinical guidelines for major incidents covering short

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342   Q247 [Dr Sanders]

343   Q248 [Dr Phull]

344   Q281 [Samantha Allen]; NHS England, *NHS Emergency Preparedness, Resilience and Response Framework* (8 July 2022)

345   Q281 [Samantha Allen]

346   Q280 [Claire Murdoch]

347   Q280 [Claire Murdoch]

348   Department for Environment Food & Rural Affairs (MH0036) para 19

349   Q316 [Gillian Keegan]

and long term "psychosocial support" for patients and staff; access to remote talking therapies or face-to-face support for people with serious mental health illnesses where clinically safe to; and all NHS mental health providers setting up 24/7 urgent helplines for people in severe need or crisis.[350]

152. UK Health Security Agency flooding health guidance to help health professionals in public health and public agencies "understand and mitigate" mental health risks associated with crises like flooding and ensure local mental health support is given to people in need.[351] As well as the National Flooding and Coastal Erosion Risk Management Strategy committing the Environment Agency to work with government, risk management authorities and health services to ensure mental health is "factored into long-term recovery planning".[352]

153. Other crisis support cited by DEFRA and DHSC includes the Government's COVID-19 mental health and wellbeing recovery action plan working to ensure more front-line staff receive Mental Health First Aid (MHFA) training. We heard the RPA and EA who deal with people in rural communities affected by animal disease outbreaks and flooding events had already made progress.[353] Also, the RPA's Financial Support Payment process trying to "address specific financial duress" with farming help organisations and issuing guidance to farmers and land managers about how to deal with difficulties because of extreme weather that affect farming payment schemes. Financial "easements" can be put in place to support farmers during a crisis period "beyond [an] agreement holder's control", by making a minor or temporary change to an agreement.[354]

154. **Crisis events can have short- and long-term effects on people's mental health, but civil society groups told us NHS support is minimal or short-term, despite greater support being likely to help people deal more successfully with trauma. Rural health providers suggested only limited local planning takes place with no extra resources being available, while NHS England suggested more funding could be made available. An ICS told us much work is underway to plan for crisis events. NHS England was focused on the "clinical" response with ICSs leading "on the ground" and expected to make best use of "tools" provided by the Government.**

155. **However, as more extreme weather events are predicted to occur, the Government and NHS England need to adopt a more proactive approach to the mental health and well-being implications of crisis and shock events rather than just leaving it to local areas. We welcome the provision of Mental Health First Aid training for front-line public sector staff working with rural communities during crises. We also welcome the fact that advice and easements are available to help farmers cope with the financial challenges.**

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350   Department for Environment Food & Rural Affairs (MH0036) paras 20–21

351   Q315 [Gillian Keegan]

352   Q317 [Lord Benyon]; Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 36; Environment Agency, *National Flood and Coastal Erosion Risk Management Strategy for England* (July 2020)

353   Q313 [Lord Benyon]; Q316 [Gillian Keegan]

354   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) paras 33–5; Q314 [Jonathan Baker]

156. *We recommend that by the end of this year, 2023:*

   a) *DEFRA and DHSC, working with all relevant public health, environmental and first responder stakeholders, assess the readiness of local plans for crisis events, and commence consultations on upgrading local preparedness for rural populations' mental health, and*

   b) *HM Treasury, DHSC, DEFRA and NHS England review current emergency funding mechanisms and how these can be improved by establishing a dedicated funding stream, to enable local areas to quickly access more resources to respond to rural communities' mental health needs during and, crucially, after crisis events.*

5   Addressing mental health in government policy and regulation

157. As already noted in Chapter 2, stress is a major issue affecting the farming community's mental health, some of which relates to government policy and activity affecting the sector. This chapter examines how DEFRA is taking account of mental health in policy and regulation to mitigate them as potential sources of stress. It also looks at the need to respond to the occupational demands placed on agricultural and veterinary workers which create mental health challenges.

158. A key source of stress reported by the farming community to *The Big Farming Survey* was public policy and the loss of farming subsidies.[355] These reflect concerns about big changes such as the Government's ELM-programme which will introduce payments to farmers and landowners to provide environmental public goods; replacing Basic Payments previously paid under the EU's Common Agricultural Policy, which are being reduced between 2021 and 2027.[356] We know this has been the source of long-standing anxiety in the farming sector because of ongoing uncertainty, expressed by witnesses during our Autumn 2022 inquiry into what progress the Government has made on ELM, how the new scheme will work and what the new payments rate will be, which we wrote to DEFRA about.[357] When DEFRA Minister Mark Spencer MP appeared before us in November, he committed to publishing further details in December that we hoped would give the sector clarity,[358] but the Secretary of State Rt Hon Dr Thérèse Coffey MP subsequently told us this would not actually happen until the New Year.[359] We recognise that ELM represents a fundamental change in policy and has to be got right so that it will work, but such delays do not help mitigate it as a source of stress. The Minister Mark Spencer MP then tabled a Written Ministerial Statement and made an Oral Statement to the House Commons on 26 January, with DEFRA issuing further details about the scheme online.[360]

The Farm Resilience Fund

159. DEFRA's initial submission said it was aware of the "link between business resilience and personal wellbeing" identified by *The Big Farming Survey*. DEFRA said, given this, it was "supporting sustainable businesses through a period of change such as the agricultural transition period [to ELM as it] will have positive impacts on wellbeing",[361]—reflecting that it knows change and uncertainty creates mental health challenges for the farming

355   Royal Agricultural Benevolent Institution, *The Big Farming Survey* (October 2021) p8; Centre for Rural Policy Research (CRPR) University of Exeter (MH0029) paras 11–12

356   Q89 [Alicia Chivers]; Q175 [Edward Richardson]; Department for Environment, Food and Rural Affairs and Rural Payments Agency, *Environmental Land Management schemes: overview* (accessed 7 December 2022); Rural Payments Agency, *Basic Payment Scheme (BPS) 2021* (August 2020)

357   Environment, Food and Rural Affairs Committee, *Oral evidence: Environmental Land Management Scheme: Progress Update, HC 621* (6 September 2022), *Letter to Rt Hon Mark Spencer MP Minister for Food, Department for Environment, Food and Rural Affairs* (24 November 2022) para 2

358   Environment, Food and Rural Affairs Committee, *Oral evidence: Environmental Land Management Scheme: Progress Update, HC 621* (15 November 2022) Q105

359   Environment, Food and Rural Affairs Committee, *Oral evidence: Work of the Department, HC 705* (6 December 2022) Qq2–9

360   HC Deb, 26 January 2023 Column 33WS Commons written ministerial statement]; Department for Environment Food & Rural Affairs, *Environmental Land Management update: how government will pay for land-based environment and climate goods and services* (January 2023)

361   Department for Environment Food & Rural Affairs (MH0036) paras 5, 12–3

community. So, DEFRA has set up the *Farm Resilience Fund* to give grants to organisations "known and trusted in the farming community", to give free support to farmers and land managers to help them adapt as Basic Payments are withdrawn and support their business planning.[362] It said the scheme focuses on business resilience but some delivery partners do offer "signposting services to expert mental health support where it is identified this is required".[363] The scheme went fully live in September 2022 and runs until March 2025 with £41 million of funding.[364]

160. We heard concerns, however, that the *Farm Resilience Fund* is not reaching those in most need, will not run long enough, does not integrate mental health and business resilience, nor make best use of established and trusted support. In oral evidence, Dr Wheeler of the CRPR said the scheme needs to be improved with the next funding round ensuring that it gives consistent advice, reaches enough farmers especially those in real need, and operates during the whole transition and after. She said the Fund's remit's does not integrate mental health enough with business resilience, so is a "missed opportunity [… when it] could be a really good opportunity" to talk about mental health, break down stigma, and signpost funds to the right places to give support.[365] Dr Rose of Reading University said the Fund's scope needs broadening "beyond business advice" to give grants to organisations like mental health charities, chaplains and others "who can really prepare farmers for very uncertain and challenging decisions".[366]

161. Melinda Raker of the charity YANA suggested the Government should not "reinvent the wheel"; but instead work with and fund the existing network that supports the farming community listed in the National Directory of Farm and Rural Support Groups, who could then provide MHFA-training and counselling.[367] Edward Richardson of the charity Farm Cornwall which provides business support in Cornwall, said it was recruiting another adviser to handle a massive increase in the charity's work in the last 12 months. He referred to Northern Ireland where the charity Rural Support receives some funding from the Department of Agriculture, Environment and Rural Affairs, suggesting an organisation which is "part of the farming community" like Farm Cornwall should get some UK Government funding to help it continue its work.[368]

Mental Health First Aid

162. We heard the Government could also take action to mitigate stress associated with regulation, compliance and inspection. The CRPR said everyone in these roles, needs to understand "their work is one of the top stressors in the farming community and […] they will frequently be engaging with people who are possibly/probably depressed and/ or experiencing high levels of anxiety." It suggested all regulatory inspectors and farm

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362   Department for Environment Food & Rural Affairs, *The Future Farming Resilience Fund: supporting farmers through transition* (March 2021) [accessed 7 December 2022]

363   Department for Environment Food & Rural Affairs (MH0036) para 13

364   Department for Environment Food & Rural Affairs, *The Future Farming Resilience Fund: supporting farmers through transition* (March 2021) 2022]; *The Future Farming Resilience Fund: an opportunity for advice providers and a call for farmer feedback* (February 2022); *Organisations giving free advice in your area (listed by county)* (November 2022) [all accessed 7 December 2022]

365   Q38 [Dr Wheeler]

366   Q39 [Dr Rose]

367   Q192 [Melinda Raker]; The *National Directory of Farm and Rural Support Groups* was set up by YANA and is now managed by the Prince's Countryside Fund. It lists sources of help across the UK by county, region and nation and includes advice about stress, depression and how to provide support.

368   Q192 [Edward Richardson]

assurance assessors should receive mental health training to ensure they approach "their work sensitively, [and can spot] the signs of poor wellbeing and [know] where to signpost people" for help and support.[369] MHFA-training was suggested for everyone who visits farms by Trudy Herniman of the volunteer group Farmerados; and Melinda Raker told us YANA was funding MHFA to train people in rural businesses who go out to farms, such as agronomists, and people who work for the Country Land and Business Association and NFU. This is so they can tell if their clients have poor mental health and have the skills and knowledge to support them.[370] She said it costs £300 to train one person and is "money well spent" giving them the skills and confidence to positively support colleagues, friends and family, and if they help ten people in the first six months, "that costs £30 for support that might make a difference to someone's life [and] would be easy to roll out".[371] Stephen Dodsworth from Darlington Farmers Auction Mart told us there are many livestock marts in the north of England but where he works staff are only trained in physical First Aid, though he often deals with farmers whose mental health he is concerned about. He suggested staff at auction marts should be trained in MHFA as visiting farmers know and trust them and are more likely to talk to them rather than a visitor, such as from a charity.[372]

163. We asked the Minister Lord Benyon how DEFRA takes account of mental health impacts when developing policy. He said the new ELM-schemes were designed to have a "less austere" inspection regime like giving business tax returns which he thought would be "appreciated by farmers who for decades have had a very top-down, rather soulless system of enforcement that sometimes leads to long periods of disallowance".[373] Jonathan Baker, Deputy Director of DEFRA's Future Farming and Countryside Programme, told us delivering the agricultural reforms depended on farmers wanting to work with DEFRA, and for ELM to be seen as "an attractive proposition" which is simple, fair and easy for farmers to engage with. He said farmers had given DEFRA "very positive feedback" about using the online self-service system it has created, without needing professional advice. He thought that what will "make a big difference" to farmers' mental health is work that DEFRA has done to change inspections, monitoring and compliance. So, when its Field Force visit farmers they now tell them visits are about giving advice rather than being punitive; and when they leave, they talk to the farmer and tell them if things are satisfactory or not, and then send a follow-up letter confirming this, whereas previously they were only contacted if there was a problem.[374]

164. We also asked how the Government would ensure the *Farm Resilience Fund* reaches those in need, help them through the agricultural transition, and how the Fund would integrate mental health and business resilience. Lord Benyon said 8,000 farmers (10%) will have received support by September 2022 and the target is to reach 32,000 (therefore 40%) by March 2025. Referring to ELM, he said the greatest mental health "benefit" for farmers would be to give them certainty that they can continue farming and a support network which shows them their options and how they can adapt.[375] Jonathan Baker said DEFRA's criteria for giving grants to Fund providers included "demonstrating connection with local communities and [being able to] integrate mental health into business support".

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369   Centre for Rural Policy Research (CRPR) University of Exeter (MH0029) paras 33 and 35

370   Qq168, 172 and 190 [Trudy Herniman]; Qq168 and 175 [Melinda Raker]

371   Q185 [Melinda Raker]

372   Qq184–88 [Stephen Dodsworth]

373   Q318 [Lord Benyon]

374   Q318 [Jonathan Baker]

375   Q320 [Lord Benyon]

And that DEFRA runs workshops with providers to ensure they can signpost people to mental health support or an agricultural charity. He said the Fund integrates wellbeing and business support, because feedback from farmers and farming stakeholders indicated they would engage with this approach which was working "quite well"; but a "stand-alone wellbeing or mental health offer would be ignored".[376]

165. We also asked the then Health Minister Gillian Keegan MP and DEFRA Minister Lord Benyon, what plans the Government had to promote MHFA-training for people working in rural areas. We were told the Government's *COVID-19 mental health and wellbeing recovery action plan* is working to ensure this training is widely available for staff in front-line roles, and its Ministerial Task and Finish Group was tracking progress by departments and arms' length bodies on training staff. Also, that the RPA and EA which deal with people in rural communities affected by animal disease outbreaks and flooding events had already made progress on this.[377]

166. **Government policies and regulatory activity are key sources of stress for the farming community so Ministers should think hard about the impact of their decisions. The Environmental Land Management (ELM) programme is a case in point given the prolonged uncertainty. DEFRA's attempt to take account of mental health at least in terms of this policy, is to provide separate mitigating support under the Farm Resilience Fund (FRF), rather than embed it into ELM. It is unclear whether it is reaching people in most need; if mental health is integrated enough with business resilience; or if it makes best use of established and trusted support groups.**

167. **We hope that DEFRA's attempt to reduce regulatory stress is a positive change in cultural practice. However, encouraging and investing in Mental Health First Aid (MHFA) training for people dealing with farmers is a pre-requisite to ensure they are skilled and able to signpost to mental health support.** *We recommend that:*

    a)   *the next round of the Farm Resilience Fund prioritises providing mental health support to the farming community as a key deliverable alongside business resilience, to ensure it is more firmly established so that farmers engage with mental health support, and*

    b)   *the Government develop an implementation plan by December 2023, to fund and roll-out the MHFA- training to front-line staff—across the public sector, auction marts, farming organisations and charities—who deal with farmers.*

Occupational support for agricultural and veterinary workers

168. As noted in Chapter 2, people's mental health can be affected by an accumulation of pressures that build up over time, but many farmers find it difficult to take time off because of the demands of their work which can negatively affect their mental health.[378] Dr Wheeler of the CRPR told us some people do manage people to take time off who generally have higher wellbeing. Dr Wheeler and Dr Rose of Reading University discussed that they may do so if their business is in a good financial position or big enough to cover their absence; but they may not be able to afford or feel able to take a break if a farm is

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376   Q320 [Jonathan Baker]

377   Q313 [Lord Benyon]; Q316 [Gillian Keegan, Zoe Seager]; Department of Health and Social Care and Cabinet Office, *COVID-19 mental health and wellbeing recovery action plan* (March 2021)

378   Centre for Rural Policy Research (CRPR) University of Exeter (MH0029) paras 14 and 22

small or "struggling with poverty."[379] Dr Wheeler also told us CRPR's research had found "an expectation" in farming that it is necessary and part of farmers' identity to work hard. She said, practical barriers do exist, but:

> We have heard 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 […] really positive […] for wellbeing and for the business.[380]

169. Veterinary workers are also under significant pressure in their animal and social caring roles.[381] As Chapters 2 and 3 have already covered, despite the mental health challenges some face we heard many can struggle to get time off due to staffing pressures and being unable to get cover for animals in their area. So, they may keep working or face "moral injury" if they need to take time off sick or may be concerned about losing their licence to practise if they disclose concerns about having suicidal thoughts.[382]

170. In addition to this, Chapter 4 noted the NHS does not always have a full understanding of the pressures that agricultural and veterinary workers are under. Whether it's the former being advised to take time off even if they feel they cannot leave the farm or get someone else to look after their animals, or a lack of flexibility in NHS appointments and treatment for veterinary workers if they are legally required to continue practising. Plus, that vets may need to be supported whilst continuing to work, and that NHS-thresholds for mental healthcare mean that people still working may not be seen as unwell enough for help.[383] Also, there is the high prevalence of suicide amongst agricultural and veterinary workers who have been identified as "high-risk" by the national suicide prevention strategy.[384] This suggests that relying on 'reactive' mental health services to address the mental health challenges which arise from occupational pressures on these workers is inadequate.

171. **The Government should look at how to respond to the occupational demands placed on farmers, agricultural and veterinary workers and any cultural barriers that: prevent these workers from taking time away from work, are detrimental for mental health without opportunity for respite, or are a block on taking time off when sick or injured to recover and to dealing with mental ill-health.**

172. *Although it will be challenging for the Government to address this given such occupations can involve lone workers in often isolated rural locations, we recommend that DEFRA sets up a working group to:*

   a)   *explore options to establish or expand models such as a cooperative or insurance cover system for agricultural workers; and a locum/ GP-holiday-cover model for veterinary workers to provide greater access to leave away from work and to take time off sick to recover from mental ill-health, and*

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379   Q11 [Dr Wheeler, Dr Rose]
380   Q11 [Dr Wheeler]
381   Bovine Tuberculosis Partnership for England [MH0030] paras 13–4
382   Qq109, 112 and 116 [Dr Allister]
383   Q89 [Alicia Chivers]; Q114 [James Russell]; Qq108–24 [Dr Allister]
384   Samaritans (MH0012) para 11, cited Office for National Statistics, *Suicide by occupation, England: 2011 to 2015* (17 March 2017); HM Government, *Suicide prevention strategy for England* (10 December 2012) p5

b)   *review provisions with the veterinary profession to consider how veterinary workers can be supported to maintain their licence to practise during periods of ill-health or sickness absence.*

6   Improving rural communities as places to live

173. In this final chapter we look at some of the wider challenges of rural life which affect people's mental wellbeing and how the Government is responding to them through levelling-up, including on rural public transport and digital connectivity. It also looks at the provision of rural youth services.

Tackling the challenges of rural life

174. As Chapter 2 noted, the overall picture of rural communities' mental wellbeing is complicated. According to the NRMHF, rural communities are expected to be "resilient and strong" and find their own solutions for declining public transport, local health services, shops, lack of job opportunities and affordable housing. This puts pressure on individuals and communities, "to come up with the answers", to provide their own broadband or community centre, or keep a GP centre open, which people and communities in towns and cities might not be expected to carry. It also said this can cause 'burn-out', leaving some communities with a "sense of being left to battle alone to keep vital communities and resources alive".[385] The Forum also told us that not everyone that moves to the countryside experiences the "idyll" of rural life, particularly as people age and they need services to be nearby; but the "realities of rural challenges [fail to be] addressed through meaningful, strategic support with and for rural communities".[386]

175. Evidence to our inquiry suggested a more strategic approach is needed to address key challenges affecting rural life. Dan Mobbs of the mental health charity MAP, which works with young people in Norfolk, told us "if you are growing up in the countryside there are advantages, low crime and the great outdoors"; but if a young person "cannot see a future" for themselves in the area they love and grew up in due to a lack of jobs and affordable housing, that can be very bad for their mental health as they look to move away, which is especially difficult if you are from a marginalised community.[387] He therefore suggested it is important to look at "what makes a good community that someone wants to live in and that includes everything" in terms of what will benefit wellbeing.[388] Samaritans' written evidence said that suicide prevention in rural communities needs to tackle "the wider determinants of health", and involve much more than just local government, DEFRA and health authorities, working together, and also include national and local action on transport, digital inclusion, economic regeneration, unemployment and accessible health services.[389] From a secondary care perspective, Dr Phull said it will be important for the new ICS in Lincolnshire to work in partnership with the voluntary sector to consider addressing local population need to tackle social or economic issues, such as housing, homelessness or other factors.[390]

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385   National Rural Mental Health Forum (MH0022) para 11
386   National Rural Mental Health Forum (MH0022) para 13
387   Q76 [Dan Mobbs]
388   Q82 [Dan Mobbs]
389   Samaritans (MH0012) para 21
390   Q245 [Dr Phull]

The Government's levelling-up ambitions

176. 'Levelling-up' is the Government's main policy for trying to reduce geographical, economic, social and health inequalities, including in rural areas, as set out in the *Levelling Up the United Kingdom* (2022) white paper.[391] The *Levelling Up and Regeneration Bill* would establish twelve 'levelling-up missions' on which the Government will have an annual duty to report.[392] Those most relevant to our inquiry are the following:-

- *Transport Infrastructure*—by 2030, local public transport connectivity across the country will be significantly closer to the standards of London, with improved services, simpler fares and integrated ticketing.

- *Digital Connectivity*—by 2030, the UK will have nationwide gigabit-capable broadband and 4G coverage, with 5G coverage for the majority of the population.

- *Health*—by 2030, the gap in Healthy Life Expectancy (HLE) between local areas where it is highest and lowest will have narrowed, and by 2035 HLE will rise by five years, and

- *Well-being*—by 2030, well-being will have improved in every area of the *UK*, with the gap between top performing and other areas closing and is an "the overarching objective" for levelling up, intended to capture "the extent to which people across the UK lead happy and fulfilling lives."[393]

177. We asked the Government what action it was taking under the levelling-up agenda to address the underlying drivers of poor mental health in rural communities and to build strong rural communities. The joint submission from DEFRA and DHSC said levelling up all of the UK including rural areas "is at the heart of the government's agenda", with the White Paper recognising rural communities' strengths, like "a high sense of local belonging and pride, [… and their] challenges such as poorer connectivity, skills and lower productive capital".[394] DEFRA and DHSC said the Government was funding levelling-up via the *UK Shared Prosperity Fund* (UKSPF) launched in April 2022, to give all areas an allocation from a £2.6 billion funding pot, recognising that "pockets of deprivation and need" exist in even in the most affluent areas, and it will help people in places of need such as rural communities to access opportunity including rural communities.[395] DEFRA and DHSC also said the Autumn 2021 Spending Review gave DEFRA funding to replace lost EU LEADER and Rural Development programme funding, which gave grants to support business productivity and growth, such as farm diversification rural community infrastructure.[396] Subsequently, in September 2022, DEFRA and DLUHC launched a £110 million *Rural England Prosperity Fund* to give rural areas targeted support via capital grants for small businesses and local communities and to top-up rural local authorities'

391   *Levelling up: What are the Government's proposals?* House of Commons Library (February 2022) p5; Department for Levelling Up, Housing & Communities, *Policy paper, Levelling Up the United Kingdom* (January 2022) p117

392   *Levelling-Up and Regeneration Bill 2022–23 - Explanatory Notes* (May 2022) pp7–10

393   Department for Levelling Up, Housing & Communities, *Levelling Up the United Kingdom* (January 2022) pp120–21 and 186. The other missions cover living standards, research and development, education, skills, pride in place, housing, crime, and local leadership.

394   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 58

395   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 60. The *UK Shared Prosperity Fund* replaces support from the EU Structural Funds.

396   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 61; European Union, *LEADER/CLLD* (accessed 3 January 2023)

UKSPF-allocations.[397] However, the response from DEFRA and DHSC did not mention what support the Government is giving to rural areas through its *Levelling Up Fund* launched in November 2020 which will spend £4 billion across England.[398] Without more detail, it was unclear what support the Government is giving for levelling-up through these various funding mechanisms against rural need, so we were keen to know how it is delivering on two key levelling-up missions to improve rural communities' wellbeing and access to mental health services—public transport and digital connectivity.

Levelling-up rural public transport

178. DEFRA's evidence acknowledged that access to mental health support is a challenge made worse by poorer public transport in rural areas for people without cars.[399] The difficulty is made apparent by DEFRA's second rural proofing progress report which states that that 50% of the rural population live in areas with the poorest accessibility to services based on minimum travel times, compared to just 2% of the urban population; and the average minimum travel time to a hospital is just over one hour in rural areas compared to just over thirty minutes in urban areas.[400]

179. As chapter 4 noted, buses are the most used method of public transport but are less economically viable to run in rural than urban areas, and may only provide a limited service which is costly and inconvenient to use involving multiple routes and long journey times.[401] Melanie Costas told us it is "very difficult" to run a bus service in counties like Dorset in which about half of the population live in rural areas.[402] For example the service must be pre-booked 24 hours ahead and is not available in the evening or weekends, reducing someone's ability to have a "social life" which may leave them feeling isolated.[403] The financial challenge of running a rural service was also highlighted by Barbara Piranty the CEO of GRCC who told us that a 'demand responsive' bus service was being procured for some of Gloucestershire's remote rural areas but it would not be economically viable to run if it is not used enough.[404] Dan Mobbs, CEO of the mental health charity MAP which works with young people in Norfolk, highlighted a current difficulty in making services available for all, as the eligibility criteria for using community transport means it is not an option for many, including young people.[405]

180. DEFRA Minister Lord Benyon told us the Government was addressing shortcomings in rural transport through the following schemes:

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397   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 61; Department for Environment, Food and Rural Affairs, *Rural England Prosperity Fund: prospectus* (September 2022) p13

398   HM Treasury, *Levelling Up Fund: prospectus* (March 2021) and *Levelling Up Fund Round 2: prospectus* (July 2022). Department for Levelling Up, Housing & Communities, *Landmark Levelling Up Fund to spark transformational change across the UK* (18 January 2023) — the latter was the second round of awards under the Levelling Up Fund.

399   Department for Environment Food & Rural Affairs (MH0036) para 1

400   Department for Environment, Food and Rural Affairs, *Delivering for Rural England – the second report on rural proofing* (September 2022) p10

401   Department for Transport, *Transport Statistics Great Britain: 2019* p3 (December 2019); Qq52 and 56 [Barbara Piranty, Melanie Costas]; Q115 [James Russell]

402   Q55 [Melanie Costas]; Dorset Council, NORDCAT Dial-a-Ride [accessed 12 December 2022]

403   Rural Mental Health Matters (MH0039) paras 2–4

404   Q56 [Barbara Piranty]

405   Q76 [Dan Mobbs]

- £20 million in 2021 under the *Rural Mobility Fund*, that DEFRA's second rural proofing progress report explained would roll-out 17 'demand response transport' pilots in rural and suburban areas by the end of 2022, to improve local transport where demand is dispersed, and distance makes it difficult to meet people's needs, and

- Over £1 billion in April 2022 for the *National Bus Strategy*, which DEFRA's second rural proofing report explained will support the development of 31 Bus Service Improvement Plans across England, including in rural counties like Norfolk, Cornwall, Derbyshire and Devon.[406]

The Minister also said DEFRA was working with the Department for Transport to ensure rural communities' needs are reflected in the Government's new *Future of Transport: Rural Strategy* due out in 2022 (yet to be published).[407] The second rural proofing report said the strategy will tackle rural mobility, improve connectivity and accessibility, so it is easier for people to access jobs, education, healthcare and opportunities to socialise; and be delivered using new technology and approaches such as demand response transport.[408]

181. We wanted to know how the Government's rural transport policies will ensure mental health services are accessible for rural communities in practice, so we specifically asked the Health Minister Gillian Keegan MP if an ICS could challenge local authority cuts to rural bus services. She said the ICS-model should ensure more join-up between the NHS and local authorities so that they can come up with an alternative solution which is "hopefully […] the right thing" for local people[409]—which did not provide certainty on the outcome.

Levelling-up digital connectivity

182. Under the LTP the NHS is expected to provide more online services by 2023–24.[410] However, many people are classed as "digitally excluded" because they either do not have access to the internet and digital technology and/or the skills to use them, according to the ONS' 2019 *Exploring the UK's digital divide* report.[411] Some evidence to our inquiry flagged that digital skills are often a problem in rural areas, particularly for older residents who prefer face-to-face services.[412] However the largest and most cited problem, as noted by our predecessor Committee's 2019 report *An Update on Rural Connectivity*, is a lack of rural digital infrastructure.[413] This was highlighted numerous times during our inquiry as many people are excluded by a lack of available broadband or speed, not being able to

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406   Q312 [Lord Benyon]; Department for Environment, Food and Rural Affairs, *Delivering for Rural England – the second report on rural proofing* (September 2022) p18

407   Q312 [Lord Benyon]

408   Department for Environment, Food and Rural Affairs, *Delivering for Rural England – the second report on rural proofing* (September 2022) p18

409   Q302 [Gillian Keegan MP]

410   NHS England, *The NHS Long Term Plan* (January 2019) pp6 and 9

411   Office for National Statistics, *Exploring the UK's digital divide* (March 2019)

412   Professor Mark Shucksmith OBE (Newcastle University), Polly Chapman (Impact Hub Inverness) and Dr Jayne Glass and Dr Jane Atterton (Scotland's Rural College, SRUC) (MH0014) paras 9–10; British Association for Counselling and Psychotherapy (BACP) (MH0021) para 16

413   Environment, Food and Rural Affairs Committee, *An Update on Rural Connectivity* p4

afford to be online or not wanting to be.[414] The Nuffield Trust's submission also said digital provision can potentially increase rural communities' access to mental health services, but restrictions on digital infrastructure are also a barrier to NHS delivery.[415]

183. We questioned the then Health Minister Gillian Keegan MP on steps the Government is taking to ensure the NHS provides equal digital access for rural and urban areas. She said "it is right" the Government ensures people have digital skills and access to broadband and devices, but were told rural communities' access to IAPT-services may have been "compromised" before the pandemic by long journeys to access therapy face-to-face, which then changed to remote provision giving people more choice and flexibility.[416] However, the joint submission from DEFRA and DHSC did acknowledge that "many rural communities have poor internet coverage", which affects their access to NHS mental health support given remotely.[417] The submission also replied to the question we raised in our evidence session with Ministers about what data the NHS collects on digital access to mental health services and patient preference amongst people in rural areas. It said that NHSE does not collect this data; but where "appropriate and safe to do so, NHS organisations continue to offer face-to-face treatment, [… including] for people who are not able to access services by other means".[418] It also said data for April 2022 showed that IAPT-appointments in England were provided as follows: 54,713 via the internet, 44,263 face-to-face, and 222,363 by telephone and other methods, but did not distinguish rural from urban areas.[419]

184. We asked DEFRA Minister Lord Benyon what progress the Government was making on rural digital inclusion. He told us 'Project Gigabit' was "making a huge difference", as the proportion of rural premises that are 'gigabit capable' had risen from 9% in 2019 to 30% by July 2022.[420] The joint DEFRA and DHSC submission said the aim is to reach "at least 85% of premises by the end of 2025 and as close to 100% as possible as soon after."[421] The Minister said it will deliver "real change" in terms of mental health and talking therapies.[422] On rural mobile phone connectivity, the Minister said the Government was pushing forward delivery of the Shared Rural Network (SRN) which he said would have benefits for the economy and if someone is "having a mental health crisis" and needs an instant phone connection.[423] The joint DEFRA and DHSC submission said the SRN began in March 2020 for which the Government and mobile network operators (MNOs) are jointly investing over £1 billion, to provide 4G mobile coverage to 95% of the UK by the end of 2025, with more progress to be made in "hard-to-reach areas" until the start of 2027.[424] It also said DCMS would publish a *Wireless Infrastructure Strategy* in 2022 to set a new

414   Q52 [Barbara Piranty]; Q79 [Dan Mobbs]

415   Nuffield Trust (MH0035) para 8

416   Q303 [Gillian Keegan MP]

417   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 11

418   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 9

419   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 10

420   Q305 [Lord Benyon]

421   Q305 [Lord Benyon]. Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 12. Note: Project Gigabit aims "to level up the UK by giving hard-to-reach areas access to gigabit-capable internet speeds."

422   Q305 [Lord Benyon]

423   Q305 [Lord Benyon]

424   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 14–18; *Shared Rural Network* [accessed 12 December 2022]

policy framework for 5G; the Government's *Product Security and Telecommunications Infrastructure Bill* will make best use of existing infrastructure and operators to improve rural connectivity; and its 2022 mobile planning reforms will support 5G's deployment.[425]

185. **Some of the challenges of rural daily life can have a significant impact on people's mental wellbeing. The UK Government needs to address these, including through its various funding routes for levelling-up; but without more detail we cannot evaluate the difference it will make. On upgrading transport infrastructure and digital connectivity the Government appears to be investing significant resources and making progress which may potentially improve rural communities' wellbeing and access to mental health services. But it needs to move much faster to push forward the new rural transport strategy, to deliver real change, so that 'demand response' bus services are embedded and sustainably financed, and to join-up rural public transport with local health planning. We also hope it will tackle the shortfall in rural digital infrastructure; but until then, flexibility in NHS digital provision will remain limited for rural communities as will the gap in digital skills unless it is addressed.**

186. *We recommend that:*

   a) *the Government set out how rural proofing has been applied to the Levelling-up and Regeneration Bill; and work with the Office for National Statistics (ONS) to rural proof the Levelling-Up metrics to ensure progress in rural areas is measured effectively*

   b) *DEFRA and HM Treasury set out the geographical distribution of projected funding for rural levelling-up against need*

   c) *the Department for Transport, DEFRA, DHSC and NHSE set out how the new rural transport strategy will provide rural communities with access to health services that is comparable to that experienced by urban communities, and*

   d) *the Department for Digital Culture Media & Sport (DCMS), NHS Digital and NHSE issue a call for evidence to rural communities, Integrated Care Systems and health providers, and about current digital access to mental health services, and consult on proposals to address any shortfall by the end of this year, 2023.*

Rural youth services

187. As Chapter 4 noted, too much reliance is placed on CAMHS which is doing a lot of "heavy lifting" for children and young people's mental health in rural areas, and more use needs to be made of non-medical forms of early intervention such as youth services.[426] However, according to the YMCA's *Out of Service* report from 2020, spending by local authorities in England on youth services fell by 71% between 2010/11 and 2018/19, from around £1.36 billion in real terms down to £398 million.[427] The associated fall in rural youth services plus less social infrastructure may have increased pressure on CAMHS

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425   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) para 19–20; *Product Security and Telecommunications Infrastructure Act 2022*

426   Q80 [Dan Mobbs]

427   YMCA, *Out of Service: A report examining local authority expenditure on youth services in England & Wales* (January 2020) p6

as "the only show in town" in rural areas, and be contributing to a model where young people only present once in crisis.[428] The Government could be looking to address this issue through 'levelling-up', in terms of children and young people's wellbeing or the provision of youth services; but it is not included in the Government's *Levelling-Up* White Paper, DEFRA's second rural proofing progress report which includes a 'rural overview' of the levelling-up missions, nor the *Levelling-Up and Regeneration Bill*.[429]

188. We therefore asked DEFRA and DHSC what action the Government is taking to support young people's wellbeing in rural areas and how it relates to funding for levelling-up. The joint submission from DEFRA and DHSC said DCMS reviewed of England's youth services in 2020 to which 6,000 young people gave feedback.[430] The published review reported that young people said youth services are "hugely important", as is the quality of provision, needing trained and committed youth workers or volunteers "to create an inclusive and welcoming environment, where young people felt supported and respected", otherwise they may dis, fruteview also found young people cited "the loss of youth provision or increase in participation fees in their areas due to funding cuts" as some of the reasons for not attending.[431]

189. The submission from DHSC and DEFRA also stated that the Government responded to the review by announcing a new 'Youth Guarantee' including £560 million of funding for levelling up. This included £368 million through the Youth Investment Fund (YIF) to be spent on areas in most need to level-up youth infrastructure, by creating or expanding up to 300 new youth centres over the next three years so that young people can get "access to youth workers and positive activities". It also said an extra £12 million was spent in Phase One of the YIF on over 400 projects in levelling-up areas including, rural areas of Cumbria, Cornwall, High Peak, East Suffolk and North Devon, so local youth providers can invest in capital projects and expand what they can offer.[432] Although the Government did publish details of both the criteria for awarding funding under Phase 1, and of those projects which received grant funding—which does show some have been given for projects to help improve the mental health of young people who are experiencing rural isolation—these do not give a fuller picture of funding against rural need and neither does the written evidence we received from DEFRA and DHSC.[433]

190. **Given the over-reliance on CAMHS in rural areas as a response to mental ill-health amongst children and young people there is an urgent need to address the**

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428   Qq76 and 80 [Dan Mobbs]; Q132 [Danny Hutchinson]; Centre for Mental Health [MH0037] para 16; Q86 [Karen Black]; Q274 [Claire Murdoch]

429   Department for Levelling Up, Housing & Communities, *Levelling Up the United Kingdom* (January 2022) p213; *Levelling-Up and Regeneration Bill 2022–23 - Explanatory Notes* (May 2022); Department for Environment, Food and Rural Affairs, *Delivering for Rural England – the second report on rural proofing* (September 2022) pp32–40

430   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) paras 72–4

431   Department for Digital, Culture, Media & Sport, *Youth Review: Summary findings and government response* (February 2022) [accessed 6 December 2022]

432   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) paras 72–4

433   Department for Environment, Food and Rural Affairs and the Department of Health and Social Care (MH0045) paras 72–4; Department for Digital, Culture, Media & Sport, *Youth Investment Fund (YIF) - places selection methodology* (January 2022), and *Phase 1 of the Youth Investment Fund: successful grantees*, (May 2022). The funding criteria were as follows: "List 1: This will be made up of 45 upper tier local authorities, who have been picked using a mix of youth needs and provision of youth services data [...and] List 2: This will be made up of 674 wards in upper tier local authorities that are not major/minor urban conurbations and where youth need/ deprivation is the highest."

shortfall in youth services. Including youth services under the levelling-up agenda would give children and young people's wellbeing the strategic prominence and profile it needs. It is therefore a missed opportunity that it has not been included in the levelling-up missions, or at least, identified as key to levelling-up in the 'rural overview' of the missions (in DEFRA's second rural proofing progress report). The Government is investing new funding to grow youth services, but we are not able to evaluate how much it addresses rural need or to what extent it is starting to bring them up to previous levels of service.

We recommend that:

a) *the Government amend the Levelling-up and Regeneration Bill to include an additional mission on young people's mental health and wellbeing and the provision of youth services; and develop a metric to measure progress with ONS, for youth services and outcomes for young people's wellbeing in rural and urban areas*

b) *DCMS and DEFRA issue a call for evidence, consulting with local government, charities and children and young people, to assess current and planned new provision for rural youth services against need, to establish if a projected shortfall remains, and*

c) *by the end of this year, 2023, DCMS and DEFRA to publish findings from the call for evidence on rural youth services and develop proposals to fund and make up for any shortfall in provision over the next ten years.*

Conclusions and recommendations

State of mental health in rural England

1.   The current data and information relating to the shape and nature of mental health specifically in rural areas, communities and occupations is regrettably incomplete or unavailable and there have been many calls over time for this to be rectified. Given the strong indications of poorer mental health and well-being in rural areas, compared to urban ones, there has been a serious failure of logic and foresight in not ensuring that relevant data are collected and at a very granular level. (Paragraph 43)

2.   While experience of nature and the countryside is consistently identified as potentially beneficial for people's mental health, our evidence is equally clear that the isolation inherent in rural living poses a significant challenge to the mental health of those who reside and work in these areas. In addition, other factors represent serious but currently unquantifiable pressures on the mental health of agricultural and veterinary workers. (Paragraph 44)

3.   We believe that, while the available evidence does not reveal a mental health crisis in rural England, there are more than enough glaring gaps, and obvious red flags, to warrant urgent and meaningful action, aiming to achieve a degree of preventative impact rather having to wait for an inevitable crisis to create a political imperative and free the necessary resource. (Paragraph 45)

4.   In particular, the long list of risks and stressors affecting the farming community and veterinary workers is perhaps the immediate priority, not least because there are real opportunities for substantial gains in this area with significant levers for change in the Government's hands. (Paragraph 46)

Suicide prevention and agricultural and veterinary workers

5.   DEFRA should be an active stakeholder in any national suicide prevention strategy, as the Department is responsible for populations and occupational groups arguably at higher-than-average risk of poor mental health and death by suicide. However, DEFRA does not appear to have carved out a clear role in the last two initiatives—the national strategy and cross-government workplan—and its only reference in the latest consultation is to managing "green social prescribing". (Paragraph 66)

6.   Adopting a more joined-up approach to public health focused on early intervention could make a positive contribution to preventing suicide amongst agricultural and veterinary workers. It would need to 'wrap-around' people at potential risk, incorporating the NHS, other key public services and the regular contacts that people have in their local community or economy, and be under-pinned by training in suicide prevention, and efforts promote working and workplace cultures that support good wellbeing. (Paragraph 79)

7.   We are very concerned by the evidence indicating that agricultural and veterinary workers have a higher-than-average suicide rate compared to the rest of the population. Although more accurate information is needed, a clear enough picture

was already established for the Government's national suicide prevention strategy (published over ten years ago) to identify both as high-risk occupational groups and take clear steps to improve the situation. Given this, we were dismayed by the lack of focus on them evident in recent strategy progress reports and the cross-government suicide prevention workplan. Compared to other departments of state and their client groups, whether prisoners, military veterans or those in serious debt, DEFRA appears to have a very limited role in this area. The Government should address this shortcoming by creating clear objectives and actions when revising the national strategy. (Paragraph 81)

8. Local government is carrying a substantial proportion of the responsibility for delivering the existing national strategy through local suicide prevention plans. However, it is unclear how much these have identified, or address, the specific needs of rural areas. Finally, we are very concerned that core local funding is not ringfenced. (Paragraph 82)

9. *We recommend that the Government:*

    a) *confirm the timeline and consultation process for revising the new National Suicide Prevention Strategy*

    b) *confirm and ringfence additional funding beyond 2023/24 for local suicide prevention to allow local authorities to contribute effectively to delivery of the national strategy, and*

    c) *commission the ONS to work with DEFRA and DHSC to address gaps in the suicide data and investigate establishing a 'real-time surveillance system' to identify trends in suicide by occupation to inform prevention policy action on suicide prevention in relation to agricultural and veterinary workers.*

    During the development of the new suicide prevention strategy, DEFRA must do better to push rural and agricultural mental health priorities to the fore, seizing a substantial role and commensurate resources to deliver progress. The Department should also establish a National Working Group on agricultural and veterinary occupations to identify immediate priorities and actions to promote more effective suicide prevention for these groups, and to develop a more joined-up public health approach to suicide prevention across the NHS, public sector and local communities. (Paragraph 83)

Rural mental health service provision, policy and strategy development

10. Although DEFRA is clearly responsible for working with the Department for Health and Social Care (DHSC) to ensure mental health policy and services are rural proofed, it is unclear what priority, resources and energy DEFRA has assigned to achieving impact in this area. The NHS Long Term Plan and Mental Health Implementation Plan, together, provide the national framework for ambitions on mental health but, again, it is unclear how far rural communities' mental health needs are being taken into account not least when, as DEFRA confirmed, it does not have adequate data in this area. (Paragraph 95)

11. DEFRA has produced a welcome framework and associated guidance for rural proofing policy but, for instance, claimed close working with DHSC and NHSE

over the new 10-year cross-government Mental health and wellbeing plan has not so far resulted in a single reference to rural priorities (rather the reverse). Furthermore, there is no indication yet that any consideration has been given to the effect of subsuming national mental health and well-being into the new holistic Major Conditions Strategy on the struggle of rural mental health for attention and appropriate prioritisation. The profile of rural mental health needs to rise much further for real progress to be made, with DEFRA taking a more active role alongside DHSC.

We recommend:

a) *DEFRA and DHSC should establish a new joint rural mental health policy and delivery team to lead and improve on current "rural proofing" of health policy; and work with NHS England to set targets to measure and improve outcomes for rural mental health services and support rural health providers.*

b) *The new joint DEFRA/DHSC rural mental health team should also set up a national working group, drawing together a range of experts, to identify practical changes to support more effective rural prioritisation within mental health services provision.*

c) *The new joint DEFRA/DHSC rural mental health team should work with NHS Digital, to evaluate the availability of data and information on rural mental health services to start to address the gaps we have identified.*

d) *DEFRA should consult on how the Rural Wellbeing Framework will be used to measure rural communities' mental health.* (Paragraph 96)

12. The solution to providing accessible rural mental health services is unlikely to be "one thing" but more likely a package involving innovation and imagination from both patients and service providers. *The new joint DEFRA/DHSC rural mental health team should consider how best to prepare and make an effective and integrated interventions with (i) the Department of Transport, and (ii) the new Department of Science, Innovation and Technology, in respect of achieving improved levels of accessibility to rural mental health services from new joined-up working, starting with the emerging rural transport strategy and Project Gigabit for rural broadband.* (Paragraph 115)

13. We conclude that NHS mental health services are often not fairly accessible for rural communities, with centralised services creating barriers to access, compounded by poor rural transport and weak digital connectivity. (Paragraph 120)

14. *Locally the NHS must focus on providing rural communities with good access to services in terms of location and/or via mobile or outreach services, through effective consultation and co-design, and bring the voluntary and community sector into the delivery landscape given its expertise in early intervention as trusted providers. It should put effort into reducing the stigma of mental health to support help-seeking behaviours.* (Paragraph 121)

15. *The NHS also needs to open-up access to the rural veterinary community to reflect restrictions on their ability to attend appointments, and support people who need to*

continue practising. Better digital provision could improve service access but must not be the default offer to rural communities, as it is not always appropriate or suitable. (Paragraph 122)

16. We believe Integrated Care Systems (ICS) will be crucial to determining whether NHS mental health services are able to respond better in future to rural communities' needs. (Paragraph 123)

17. We recommend the joint rural mental health policy and delivery team issue a call for evidence on the effectiveness of the ICS-model for providing rural communities with access to mental health services and publish its findings with proposals to address any shortcomings, by the end of March 2024. The team should work with rural ICSs, health providers, and charities, to identify cost-effective care pathways to increase provision and remove barriers to NHS treatment for agricultural and veterinary workers, by increasing flexibility in appointments times, options for care, and location of services including outreach at auction marts. (Paragraph 124)

18. Child and Adolescent Mental Health Services (CAMHS) have been under intense pressure for many years, but a lack of alternative rural social infrastructure and a fall in support for youth services means CAMHS is often the "only show in town". However, focussing on providing 'reactive' mental health services will only go so far, especially given CAMHS waiting times, so the focus and resources need to shift to prevention. Early intervention via Mental Health Support Teams (MSHTs) is a positive development but needs to be rolled-out to all rural schools as soon as possible and adequately resourced with appropriately trained staff given the many responsibilities on schools. Youth service provision in rural areas also needs to be expanded but until that is delivered, whilst demand is high on CAMHS, and alongside MHSTs, much more investment is needed in other forms of prevention such as 'Early Support Hubs'. *Therefore, we recommend that DHSC, NHS England and DEFRA consult on proposals to reduce reliance on CAMHS by expanding preventative mental health support for children and young people by, (a) setting out a path to expand provision of MHSTs to 100% of schools and colleges in rural areas by 2026/27, and (b) committing to establish and fund 'Early Support Hubs' that can be accessed by children and young people in rural areas by 2024/25.* (Paragraph 133)

19. It is very important for the farming and veterinary communities to feel that their circumstances are understood by NHS staff when seeking to access, or receiving, support (otherwise this may work against help-seeking behaviours). Charities with specialist-knowledge can gain people's trust from a position of credibility, so it makes sense to engage them to boost NHS staff understanding and/or to develop occupationally specific mental health initiatives, to provide a model for the NHS to improve support for farming and veterinary mental health. *We recommend that DHSC and DEFRA identify farming and veterinary mental health as high priorities for action and by September 2023, develop a work programme with NHS England, public health and agricultural and veterinary charities to identify measures and targets to improve mental health outcomes for these occupational groups; and that DHSC mandate Health Education England to work with agricultural and veterinary charities to develop a training programme for rural NHS providers and staff to be launched by Autumn 2023, about these occupational groups' mental health needs to improve their care.* (Paragraph 136)

20. We welcome the Government's commitment to provide more funding for mental health and to ensure local mental health spending increases by the same proportion as overall increases in local health funding. Despite this, we are concerned by the possibility that the system used by NHS England to allocate funding fundamentally disadvantages rural areas. The Government's settled view is that the system is fair and balances a range of complex criteria. We consider more work to be needed to ensure that appropriate resources fully respond to rural communities' mental health needs and reflect the additional costs that rural areas must carry as, if this is not the case, rural communities will remain disadvantaged. We are pleased the Government is working to address shortcomings in how rural deprivation is measured. *However, we ask the Department to provide us with a detailed statement of the process and the formula, in reply to this report, upon which to seek assurances from an independent source such as the National Audit Office.* (Paragraph 143)

21. *We recommend that DEFRA and the Department for Levelling Up, Housing and Communities set out a timeline and process by which to review and revise the Index of Multiple Deprivation with the aim of more accurately capturing rural deprivation. The Government should commit to reaching a position by the end of this year, 2023, whereby it can commence a consultation on draft changes to the Index and guidance for decision-makers, and how the Index should be used to support funding decisions.* (Paragraph 144)

22. Crisis events can have short- and long-term effects on people's mental health, but civil society groups told us NHS support is minimal or short-term, despite greater support being likely to help people deal more successfully with trauma. Rural health providers suggested only limited local planning takes place with no extra resources being available, while NHS England suggested more funding could be made available. An ICS told us much work is underway to plan for crisis events. NHS England was focused on the "clinical" response with ICSs leading "on the ground" and expected to make best use of "tools" provided by the Government. (Paragraph 154)

23. However, as more extreme weather events are predicted to occur, the Government and NHS England need to adopt a more proactive approach to the mental health and well-being implications of crisis and shock events rather than just leaving it to local areas. We welcome the provision of Mental Health First Aid training for front-line public sector staff working with rural communities during crises. We also welcome the fact that advice and easements are available to help farmers cope with the financial challenges. (Paragraph 155)

24. *We recommend that by the end of this year, 2023*:

a) DEFRA and DHSC, working with all relevant public health, environmental and first res*ponder stakeholders, assess the readiness of local plans for crisis events, and commence consultations on upgrading local preparedness for rural populations' mental health, and*

b) *HM Treasury, DHSC, DEFRA and NHS England review current emergency funding mechanisms and how these can be improved by establishing a dedicated*

funding stream, to enable local areas to quickly access more resources to respond to rural communities' mental health needs during and, crucially, after crisis events. (Paragraph 156)

Addressing mental health in government policy and regulation

25. Government policies and regulatory activity are key sources of stress for the farming community so Ministers should think hard about the impact of their decisions. The Environmental Land Management (ELM) programme is a case in point given the prolonged uncertainty. DEFRA's attempt to take account of mental health at least in terms of this policy, is to provide separate mitigating support under the Farm Resilience Fund (FRF), rather than embed it into ELM. It is unclear whether it is reaching people in most need; if mental health is integrated enough with business resilience; or if it makes best use of established and trusted support groups. (Paragraph 166)

26. We hope that DEFRA's attempt to reduce regulatory stress is a positive change in cultural practice. However, encouraging and investing in Mental Health First Aid (MHFA) training for people dealing with farmers is a pre-requisite to ensure they are skilled and able to signpost to mental health support. *We recommend that:*

    a) *the next round of the Farm Resilience Fund prioritises providing mental health support to the farming community as a key deliverable alongside business resilience, to ensure it is more firmly established so that farmers engage with mental health support, and*

    b) *the Government develop an implementation plan by December 2023, to fund and roll-out the MHFA- training to front-line staff—across the public sector, auction marts, farming organisations and charities—who deal with farmers.* (Paragraph 167)

27. The Government should look at how to respond to the occupational demands placed on farmers, agricultural and veterinary workers and any cultural barriers that: prevent these workers from taking time away from work, are detrimental for mental health without opportunity for respite, or are a block on taking time off when sick or injured to recover and to dealing with mental ill-health. (Paragraph 171)

28. *Although it will be challenging for the Government to address this given such occupations can involve lone workers in often isolated rural locations, we recommend that DEFRA sets up a working group to:*

    a) *explore options to establish or expand models such as a cooperative or insurance cover system for agricultural workers; and a locum/ GP-holiday-cover model for veterinary workers to provide greater access to leave away from work and to take time off sick to recover from mental ill-health, and*

    b) review provisions with the veterinary profession to consider how veterinary *workers can be supported to maintain their licence to practise during periods of ill-health or sickness absence.* (Paragraph 172)

Improving rural communities as places to live

29.   Some of the challenges of rural daily life can have a significant impact on people's mental wellbeing. The UK Government needs to address these, including through its various funding routes for levelling-up; but without more detail we cannot evaluate the difference it will make. On upgrading transport infrastructure and digital connectivity the Government appears to be investing significant resources and making progress which may potentially improve rural communities' wellbeing and access to mental health services. But it needs to move much faster to push forward the new rural transport strategy, to deliver real change, so that 'demand response' bus services are embedded and sustainably financed, and to join-up rural public transport with local health planning. We also hope it will tackle the shortfall in rural digital infrastructure; but until then, flexibility in NHS digital provision will remain limited for rural communities as will the gap in digital skills unless it is addressed. (Paragraph 185)

30.   *We recommend that*:

a)   *the Government set out how rural proofing has been applied to the Levelling-up and Regeneration Bill; and work with the Office for National Statistics (ONS) to rural proof the Levelling-Up metrics to ensure progress in rural areas is measured effectively*

b)   *DEFRA and HM Treasury set out the geographical distribution of projected funding for rural levelling-up against need*

c)   *the Department for Transport, DEFRA, DHSC and NHSE set out how the new rural transport strategy will provide rural communities with access to health services that is comparable to that experienced by urban communities, and*

d)   *the Department for Digital Culture Media & Sport (DCMS), NHS Digital and NHSE issue a call for evidence to rural communities, Integrated Care Systems and health providers, and about current digital access to mental health services, and consult on proposals to address any shortfall by the end of this year, 2023.* (Paragraph 186)

190.   Given the over-reliance on CAMHS in rural areas as a response to mental ill-health amongst children and young people there is an urgent need to address the shortfall in youth services. Including youth services under the levelling-up agenda would give children and young people's wellbeing the strategic prominence and profile it needs. It is therefore a missed opportunity that it has not been included in the levelling-up missions, or at least, identified as key to levelling-up in the 'rural overview' of the missions (in DEFRA's second rural proofing progress report). The Government is investing new funding to grow youth services, but we are not able to evaluate how much it addresses rural need or to what extent it is starting to bring them up to previous levels of service. (Paragraph 190)

We recommend that:

a)   *the Government amend the Levelling-up and Regeneration Bill to include an additional mission on young people's mental health and wellbeing and the*

provision of youth services; and develop a metric to measure progress with ONS, for youth services and outcomes for young people's wellbeing in rural and urban areas

b) *DCMS and DEFRA issue a call for evidence, consulting with local government, charities and children and young people, to assess current and planned new provision for rural youth services against need, to establish if a projected shortfall remains, and*

c) *by the end of this year, 2023, DCMS and DEFRA to publish findings from the call for evidence on rural youth services and develop proposals to fund and make up for any shortfall in provision over the next ten years.*

Formal minutes

Tuesday 9 May 2023

Members present

Sir Robert Goodwill, in the Chair

Geraint Davies

Rosie Duffield

Barry Gardiner

Dr Neil Hudson

Draft Report (*Rural Mental Health*) proposed by the Chair, brought up and read.

Ordered, That the Chair's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 190 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Fourth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134).

Adjournment

Adjourned till Wednesday 24 May 2023 at 2.00 p.m.

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Department for Environment, Food and Rural Affairs; **Jonathan Baker**, Deputy Director, Future Farming and Countryside Programme,, Department for Environment, Food and Rural Affairs

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

MH numbers are generated by the evidence processing system and so may not be complete.

1   Administrative Data Agricultural Research Collection project team (MH0017)

2   Bovine Tuberculosis Partnership for England (MH0030)

3   British Association for Counselling and Psychotherapy (MH0021)

4   British Association for Shooting and Conservation (MH0013)

5   Centre for Mental Health (MH0037)

6   Centre for Rural Policy Research (CRPR) University of Exeter (MH0029)

7   Charlton, Dr Morris (MH0008)

8   Cotswolds Community Wellbeing Service (MH0040)

9   Countryside Alliance (MH0031)

10   Defra (MH0036)

11   Department for Environment, Food and Rural Affairs and Department of Health and Social Care (MH0045)

12   Hampshire County Council (MH0041)

13   Kamau-Mitchell, Dr. Caroline (Senior Lecturer, Birkbeck, University of London) (MH0025)

14   Kelly, Susan (MH0026)

15   Killen, Mr Robert (Land Agent, Charlton Park and Bromesberrow Estates) (MH0001)

16   King Forbes, Miss Viola (Research Coordinator, University of Oxford) (MH0032)

17   Little, Mr Roger (MH0027)

18   Morgan, Mr Francis (MH0034)

19   NFU (MH0028)

20   NHS England (MH0044)

21   National Rural Mental Health Forum (MH0022)

22   Nuffield Trust (MH0035)

23   Piranty, Barbara (MH0038)

24   Rose, Dr David (Elizabeth Creak Associate Professor of Agricultural Innovation and Extension, University of Reading); Shortland, Dr Faye (Postdoctoral Researcher, University of Reading); Hurley, Dr Paul (Postdoctoral Researcher, University of Reading); Little, Dr Ruth (Lecturer in Human Geography, University of Sheffield); Nye, Dr Caroline (Postdoctoral Researcher, University of Reading); Lobley, Professor Matt (Director of the CRPR, University of Exeter); and Hall, Dr Jilly (MH0007)

25   Rural Action Derbyshire (MH0006)

26   Rural Mental Health Matters (MH0039)

27   Samaritans (MH0012), (MH0042)

28   Shucksmith, Professor Mark (Professor of Planning, Newcastle University); Chapman, Polly (Chief Executive, Impact Hub Inverness); Glass, Dr Jayne (Senior Researcher, Scotland's Rural College (SRUC)); and Atterton, Dr Jane (Manager, Rural Policy Centre, Scotland's Rural College (SRUC)) (MH0014)

29   Simons, Geoff (Senior Countryside Ranger at Local authority) (MH0023)

30   Smith, Dr Kreseda (Rural Criminologist; Lecturer in Land Information Skills, Harper Adams University) (MH0005)

31   The Country Land and Business Association (MH0024)

32   The Farming Community Network (MH0009)

33   The Gamekeepers' Welfare Trust (MH0010)

34   The Trails Trust (MH0033)

35   Williams, Mr Owen (Wildlife Artist, Self employed) (MH0004)

36   YANA (MH0011)

37   Yorke, Mr Rob (Founder, Rob Yorke Track II Enviro Dialogue) (MH0016)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2022–23

Number	Title	Reference
1st	Australia FTA: Food and Agriculture	HC 23
2nd	Pre-appointment hearing for the Chair-designate of the Environment Agency	HC 546
3rd	The price of plastic: ending the toll of plastic waste	HC 22
1st Special	Tree Planting: Government Response to the Committee's Third Report of Session 2021–22	HC 323
2nd Special	Labour shortages in the food and farming sector: Government Response to the Committee's Fourth Report of Session 2021–22	HC 412
3rd Special	Australia FTA: Food and Agriculture: Government Response to the Committee's First Report	HC 700
4th Special	The price of plastic: ending the toll of plastic waste: Government Response to the Committee's Third Report	HC 1044

Session 2021–22

Number	Title	Reference
1st	Moving animals across borders	HC 79
2nd	Environmental Land Management and the agricultural transition	HC 78
3rd	Tree planting	HC 356
4th	Labour shortages in the food and farming sector	HC 713
5th	Pre-appointment Hearing: Chair of Ofwat	HC 1253

Session 2019–21

Number	Title	Reference
1st	COVID-19 and food supply	HC 263
2nd	Pre-appointment hearing for the Chair-Designate of the Office for Environmental Protection (OEP)	HC 1042
3rd	The UK's new immigration policy and the food supply chain	HC 231
4th	Flooding	HC 170
5th	Air Quality and coronavirus: a glimpse of a different future or business as usual	HC 468

Number	Title	Reference
6th	Public Sector Procurement of Food	HC 469
7th	Covid-19 and the issues of security in food supply	HC 1156
8th	Seafood and meat exports to the EU	HC 1189