National Rural Mental Health Survey Scotland

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Rural Policy Centre

National Rural Mental Health Survey Scotland: Report of Key Findings

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With Dr Elliot Meador and Dr Michael Spencer

13th April 2017

Leading the way in Agriculture and Rural Research, Education and Consulting

Contents

Foreword: the power of partnership working

This report has come about through shared need. Both of our organisations – **Support in Mind Scotland** and the **Rural Policy Centre of Scotland's Rural College** – recognised a significant gap in our knowledge: a systematic understanding of how people with mental ill health experience their day to day lives across rural Scotland. We each had anecdotal evidence, accumulated over years of engaging with service users and from knowledge of specific needs for example within the farming community, but we did not have a clear picture across the country. In addressing this knowledge gap, a fundamental driver for us was that this picture *had* to be created by those who have first-hand experience of mental ill health, from the islands in the north and west, to the mainland areas in the south and east, from more accessible rural communities through to the very remotest parts.

Addressing this complex and sensitive subject required partnership working, and we have been delighted not only to bring our two organisations together to produce this new evidence-base, but also - through the process – to create a new partnership: the **National Rural Mental Health Forum** which came into being in November 2016. In March 2017 the Forum received pump-priming funding from the Cabinet Secretary for Rural Economy and Connectivity, with the aim of bringing together rural and mental health organisations at a national level, to raise awareness of mental ill health in rural Scotland, and identify means to address social isolation and related issues. The Government's new Mental Health Strategy, published in March 2017, recognises rural issues and their links with mental ill health, and has identified the National Rural Mental Health Forum as being the key mechanism and channel for moving forward in this critically important area.

Our ambition is that the evidence in this report continues to have impact on policy and practice across Scotland at national level and in many rural areas, through people and organisations using the findings to inform how they provide support and engage with those experiencing mental ill health in their communities.

We are absolutely indebted to the hundreds of individuals who chose to tell us their thoughts and feelings, expressing their views as to what needs to change in mental health services and highlighting key policy issues. Our role has simply been to provide a channel for these respondents' voices, to *make the invisible visible*.

Frances Simpson, Chief Executive, Support in Mind Scotland.
Professor Sarah Skerratt, Director, Rural Policy Centre, Scotland's Rural College.

Executive Summary

1. **Background:**
    a. Understanding of rural people's experiences of mental ill health in rural Scotland is largely anecdotal. A more systematic analysis was needed, in order to (i) identify whether rural-specific issues exist, and (ii) inform policy and practice.
    b. To enable this sensitive topic to be approached appropriately, a partnership was formed between SRUC's Rural Policy Centre and Support in Mind Scotland (SiMS), bringing together complementary skills and knowledge of rural Scotland and mental ill health respectively.
    c. The research was carried out when the national Mental Health Strategy was being refreshed, and while preparations are in progress for a Suicide and Self-Harm Strategy/Plan, a Dementia Strategy and a national Strategy to tackle Social Isolation.
    d. In March 2017, the Scottish Government published its new, ten-year Mental Health Strategy, recognising rural issues of isolation and service provision, and the central role of the new National Rural Mental Health Forum in creating connections between communities to address isolation and improve mental wellbeing.
2. **Methodology:**
    a. *Scoping phase:* two service-user-focused workshops were co-hosted by SRUC/SiMS in June 2016 (Inverness and Dumfries) to form the basis for the survey questions.
    b. *Online (Survey Monkey) and offline (paper) survey:* targeted at those experiencing mental ill health within rural Scotland, publicised through SiMS database, professional networks of SRUC and SiMS and via social media (Twitter and Facebook).
    c. *Questions:* open and closed, covering personal characteristics, self-reported mental health issues, Warwick-Edinburgh categories of mental wellbeing, public transport and mental health services, geographical remoteness, importance of community, desired changes to mental health services and key messages to policy makers.
    d. *Analysis:* mixed methods, using quantitative (SPSS, R, ArcGIS, Descriptive analysis, T-tests and chi squared tests) and qualitative (Thematic Analysis) approaches.
3. **Key findings:**
    a. *Survey sample:* 343 responses were received from those experiencing mental ill health across rural Scotland, covering 94 postcode areas from Remote through to Accessible rural. The highest number of responses came from the Dumfries and Galloway postcode area. Respondents were 273 female, 70 male, the majority in the 45-54 age cohort, with almost 50 aged 16-24. The majority were in paid employment, self-employed or on government training, with less than 50 unable to work – generating new evidence from those employed who also experience mental ill health. Occupations were spread across business, finance and the public sector.
    b. *Respondents' self-reported mental health issues:* 197 people reported depression (67% of the sample), 87 people reported generalised anxiety disorder (29%), 64 people reported suicidal thoughts and feelings (22%), 53 people reported social anxiety disorder (18%) with 35 reporting self-harming behaviour (12%). This was during the four-week period of August-September 2016. Percentages of those self-reporting were similar for

males and females, and were also spread across ages, both patterns running counter to some stereotypical expectations.

c. *Geographical location and distance to mental health facilities:* respondents' partial postcodes (e.g. KW14 or TD11) enabled the comparison of *actual* geographical location against *perceived* geographical remoteness. There was no clear link between the two, except for those living in "Remote rural", with 80% of those living in Remote small towns and 50% of those living in Accessible rural Scotland considering themselves to be geographically remote. The majority of respondents stated that public transport acts as a barrier to them receiving proper care needed to manage their mental health, a situation which worsened for those self-reporting suicidal thoughts and feelings, and self-harming behaviour. This can lead to a "layering" of isolation factors.

d. *Community support and connections:* community is experienced in many different ways by survey respondents, with local connections being close and strong for some, while being judgemental and parochial for others. Responses are mixed with respect to the extent to which respondents feel supported by their community or can rely on community members when an urgent but non-life-threatening mental wellbeing issue arises. The majority of respondents do *not* feel they can be open about their mental health problems in their community. Similarly, respondents express a variety of advantages and disadvantages about where they live, in relation to their local community.

e. **Key question 1: If you could change *one thing* about mental health services in rural Scotland, what would it be and why?**
    i. There is a strong need and desire to create ways for people to connect with one another *before* their personal crises occur;
    ii. These connections need to be "low-level", in non-clinical and informal settings, through trusted people and networks;
    iii. Services need to be close to the place of need, designed to include mobile services and outreach, particularly on the islands; this "outreach" approach recognises the significant stress of travelling to appointments for those with mental ill health;
    iv. Mental health care must be mainstreamed within the NHS and not a "bolt-on";
    v. There must be parity between mental and physical health care;
    vi. There must be an increased focus on the needs of children and young people, reducing waiting times, particularly in relation to self-harming.

f. **Key question 2: What key message do you want to tell policy makers to help you manage your mental ill health in a rural setting?**
    i. Mental ill health is an invisible illness – made more invisible by being rural and remote;
    ii. Users of mental health services must be listened to and respected;
    iii. Mental ill health does lead to death – it is a serious issue;
    iv. There must be shorter waiting times to see specialists;
    v. There must be support for "low-level" contact outwith hospital environments, close to communities.

4. Implications of findings:

a. *Legitimacy:* this research has presented the voices of those experiencing mental ill health in rural Scotland. Those responding stated that they were experiencing a range of mental health issues; this makes their views no less valid, in fact it *enhances* their validity, given the focus is on their experiences and proposals for what needs to change to improve their mental wellbeing in a rural setting.

b. *Communities:* the research has uncovered significant complexities around the extent to which respondents feel that their communities are supportive of them. This is extremely important in and of itself, in terms of overcoming social isolation and addressing issues of stigma and prejudice. It is also important due to the direction-of-travel, in policy and practice, towards community-based health and social care. There is work to be done in understanding how to engender and support well connected communities so that they can provide the appropriate "low-level, non-clinical, local, trusted" approaches called for by respondents, and how the work of the *National Rural Mental Health Forum* can support this inclusive shift at national and regional levels.

c. *Policy:* there is a need to continue to feed evidence from the rural survey into the National Rural Mental Health Forum and the ten-year Mental Health Strategy, as well as the Suicide and Self-Harm Strategy/Action Plan and the National Strategy to tackle Social Isolation. The new survey evidence is also of relevance to: *Community Empowerment (Scotland) Act 2015* (e.g. through Community Planning Partnerships and their Local Outcome Improvement Plans); the 2016/17 *Enterprise and Skills Review*; *"Our Islands Our Future"* and the *Islands Bill;* the Rural Economy and Connectivity portfolio of the Scottish Government; as well as to the specific Actions of the Mental Health Strategy around inclusive employment (Actions 36 and 37).

d. *Evidence:* The ultimate aim of this new rural evidence is to improve people's mental wellbeing. *Although the numbers of these rural voices will always remain small, due simply to being a part of only one fifth of Scotland's population spread over 98% of its land mass, they nonetheless provide a compelling and authentic evidence base from which to build learning and tailored support.*

Acknowledgements

Firstly, we would like to acknowledge the time taken by the survey respondents in filling in the survey, in being open in their responses, particularly in giving their thoughts and suggestions around rural mental health services and key messages to policy makers. Without their considered input, this report could not have been written.

Secondly, we are grateful for the feedback and input from the members of the National Rural Mental Health Forum, on the initial exploration of the survey findings in November 2016, and their subsequent comments at the second meeting of the Forum in March 2017. Their thoughts and reflections have helped guide elements of this report, with the usual disclaimer applying - that any errors and omissions remain those of the authors.

Thirdly, we appreciate the publicising of the online and offline survey by colleagues in SiMS, SRUC and more widely through mental health charity networks, and colleagues throughout the "rural world" who shared and re-Tweeted the postings on Facebook and Twitter, to enable people in as many parts of rural Scotland as possible to know about the survey, and to have the opportunity to respond.

Fourthly, I would like to acknowledge the quantitative data analytics of Dr Elliot Meador and Dr Michael Spencer (SRUC) whose work has been presented at the two meetings of the Forum, the Cross Party Group in the Scottish Parliament on Rural Policy and in this Report, alongside the qualitative findings from the survey. Their insights have contributed to the rich narrative from across Scotland's rural communities.

Finally, we would like to thank the Scottish Government's Rural Communities Policy Team for their engagement and commitment as we have delivered the first and second stages of the analysis with stakeholders. We have greatly valued their consistent encouragement and support throughout. We are also grateful for RESAS Underpinning funds which contributed towards analysis of the data and report-writing.

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Background

This research into rural mental health in Scotland originally stemmed from the Rural Policy Centre's *Rural Scotland in Focus* process – a two-yearly set of reports which set out evidence on the "state of rural Scotland" around a range of key issues[1]. The evidence from these reports informs policy-makers at national, regional and local levels in Scotland, and is used by a wide range of stakeholders nationally and internationally.

In scoping the Community Empowerment section for the 2016 report, it was evident that our *understanding of rural people's experiences of mental ill health in Scotland* was largely anecdotal, based primarily on people's awareness of individual cases (particularly amongst the farming population). It therefore became clear that there was a need to enhance our understanding through a more systematic analysis, in order to be able to inform policy and practice colleagues as to whether there were any rural-specific concerns, issues or opportunities which needed to be highlighted. We did not know at that stage whether "rural" led to people experiencing their mental health issues in particular ways; however, if this *did* turn out to be the case, then our work could create an evidence-base showing the need for tailoring to rural contexts.

In order to ensure that this sensitive topic was approached appropriately, a partnership was then formed between SRUC and the national mental health charity, Support in Mind Scotland[2] (SiMS) whose service provision is primarily in rural Scotland. This brought together complementary sets of skills and knowledge: understanding of the rural context and the opportunities and constraints it provides (SRUC) with the knowledge and understanding of service users experiencing mental ill health in rural areas (SiMS). This partnership also meant that the work could reach service users, ensuring they were given a voice to express their experiences of living in rural Scotland, through two workshops and the national survey (see next section).

We carried out the research at a time when Scotland's National Mental Health Strategy was being refreshed, and when preparations were in progress for a Dementia Strategy (2017), a Suicide and Self-Harm Strategy/Plan (2018) and a National Strategy to tackle Social Isolation (2017/18). In March 2017, the Scottish Government's new, ten-year **Mental Health Strategy**[3] was published, which recognises specific issues around "access to services and support for those living in remote and rural communities" (p.11) and that "the challenge presented by isolation is keenly felt by many in our rural communities" (p.20).

As part of the research process, we shared the findings of the survey in two workshops and in the Scottish Parliament. In November 2016, we talked through the initial analysis with members of the newly-formed **National Rural Mental Health Forum**, whose members specifically met to discuss the survey findings and identify an action plan based on the key emerging points. In March 2017, we presented a more detailed analysis to the second meeting of the National Rural Mental Health

[1] https://www.sruc.ac.uk/info/120428/rural_scotland_in_focus
[2] https://www.supportinmindscotland.org.uk/
[3] http://www.gov.scot/Resource/0051/00516047.pdf

Forum, as well as to the Cross Party Group in the Scottish Parliament on Rural Policy comprising a wider group of stakeholders including Members of the Scottish Parliament (MSPs).

In the 2017 national Mental Health Strategy, there is recognition of the new Forum with a specific Action to support it:

> "The National Rural Mental Health Forum has been established to help people in rural areas maintain good mental health and wellbeing. This Forum will help develop connections between communities across rural Scotland, so that isolated people can receive support when and where they need it." (p.20)
>
> **Action 12:** Support the further development of the National Rural Mental Health Forum to reflect the unique challenges presented by rural isolation.

Our research has also been developed at a time when the Scottish Government is re-emphasising its direction of travel in health and social care as being towards an increased focus on early intervention, prevention and self-management, with people being based in their communities for as long as possible. Initiatives include the integration of Health and Social Care, and Self-Directed Support (SDS). As the new National Mental Health Strategy states:

> "The Scottish Government's ambition is for a sustainable health and social care system which helps to build resilient communities. There needs to be a strategic shift towards recovery models focused on assets, strengths and self-management." (p.35).

It is becoming increasingly important, therefore, to ensure we can provide evidence on how this policy and practice journey translates into a *rural* context for those experiencing mental ill health. This evidence need also links with the Strategy's approach to Data and Measurement (p.37), where the Government outlines how they will develop a Mental Health Strategy data framework, with the aim of having data "that is useful to planners of services, clinicians and people developing policy". Producing useful data is also our fundamental aim, with our ambition being that these findings will continue to feed into the implementation, monitoring and evaluation of the Mental Health Strategy, and associated strategies, throughout the coming ten year period.

Methodology

Introduction

As stated above, the research was devised through a partnership between Scotland's Rural College (SRUC) and Support in Mind Scotland (SiMS). We held two scoping workshops followed by a national survey. The approach to these two elements is described below, together with an overview of how we analysed the survey data.

Two service-user-focused workshops

As a precursor to the online survey, SRUC and SiMS held two joint workshops in June 2016, in the north and south of Scotland: Inverness and Dumfries. These brought together service users with providers, along with a breadth of rural organisations - a combination of people who would not typically meet. Participants were asked to identify whether there were any uniquely rural characteristics to experiencing mental ill health in rural Scotland – as service users and/or as providers, and if so, what would be their priorities in addressing these issues. These scoping workshops gave background evidence on which we subsequently built the survey.

The national survey

Sampling:

Targeting: the survey was specifically targeted at those experiencing mental ill health within rural Scotland. It was not intended to be statistically representative either of Scotland's rural population, or of those experiencing mental ill health across rural Scotland. Therefore, in reporting the findings, it is important that conclusions drawn from the data are restricted to the responses from the survey itself.

Selection: the survey was publicised through the membership database of Support in Mind Scotland, through the professional networks of the SiMS and SRUC researchers, and through social media, primarily Facebook and Twitter.

Geographic targeting: we undertook this through social media, identifying those areas where low responses had been received, tagging areas and agencies within areas. This led to increased responses from under-represented areas during the four week survey period (see Fig.1):

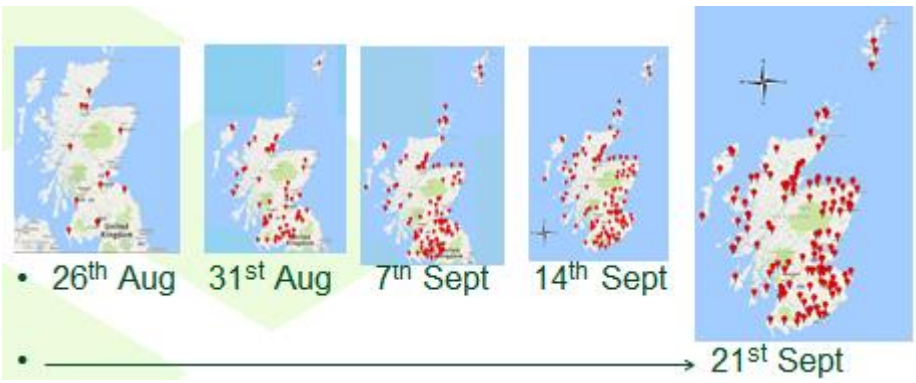

Figure 1: Geographical targeting through Twitter and Facebook, August/September 2016

Format:

Online/offline: the survey was designed to be available in online and offline formats. For those wishing to fill the questionnaire in offline, potentially with their carers, a paper copy was made available through SiMS. For those wishing to complete the survey online, a link was sent to the online questionnaire which was available via Survey Monkey; responses were automatically saved and anonymised for analysis by SRUC researchers.

Questions: The survey comprised a combination of quantitative and qualitative questions (see Appendix 1 for a summarised version). The themes covered were:

- Personal characteristics (part-postcode, age, gender, whether live on own, employment status, approximate income, occupation and whether or not a carer)
- Self-reported mental health issues (from a list of 15 recognised issues)
- Self-reported Warwick-Edinburgh categories of mental wellbeing (see below)
- Public transport issues related to accessing mental health services
- Where I live (remoteness; whether perceived to be good/bad in relation to mental health)
- Ease of accessing services
- Importance of my local community to me (series of questions around community support)
- Three open-ended questions:
    - If you could change ONE THING about mental health services in rural Scotland, what would that be and why?
    - What KEY MESSAGE do you want to tell policymakers to help you manage your mental ill health in a rural setting?
    - If you could change ONE THING about your life in rural Scotland, what would it be and why?

The **list of 15 mental health issues** which respondents could choose to self-report, were as follows:

14. Do you suffer from any of the following issues related to mental health and wellbeing? **Please choose all that apply.**

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

If you are currently experiencing suicidal thoughts or feelings please seek help. You can call Samaritans on 116123 (freephone), you can contact a trusted health professional.

Figure 2: Mental health and wellbeing issues which survey respondents could self-report

The **Warwick-Edinburgh Mental Wellbeing Scale**[4] comprises a list of questions which ask the respondent to reflect on how they have been feeling for the past two weeks (Fig.3). The purpose of using the Scale in the survey was to enable us, where appropriate and feasible, to compare the findings from the rural survey sample with the national population findings from the Scottish Health Survey.

10. For each question below, please choose the box that best describes your experience over the **last 2 weeks.**

	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	[ ]	[ ]	[ ]	[ ]	[ ]
I've been feeling useful	[ ]	[ ]	[ ]	[ ]	[ ]
I've been feeling relaxed	[ ]	[ ]	[ ]	[ ]	[ ]
I've been feeling interested in other people	[ ]	[ ]	[ ]	[ ]	[ ]
I've had energy to spare	[ ]	[ ]	[ ]	[ ]	[ ]
I've been dealing with problems well	[ ]	[ ]	[ ]	[ ]	[ ]
I've been thinking clearly	[ ]	[ ]	[ ]	[ ]	[ ]
I've been feeling good about myself	[ ]	[ ]	[ ]	[ ]	[ ]
I've been feeling close to other people	[ ]	[ ]	[ ]	[ ]	[ ]
I've been feeling confident	[ ]	[ ]	[ ]	[ ]	[ ]
I've been able to make up my own mind about things	[ ]	[ ]	[ ]	[ ]	[ ]
I've been feeling loved	[ ]	[ ]	[ ]	[ ]	[ ]
I've been interested in new things	[ ]	[ ]	[ ]	[ ]	[ ]
I've been feeling cheerful	[ ]	[ ]	[ ]	[ ]	[ ]

Figure 3: The Warwick-Edinburgh Mental Wellbeing Scale

[4] The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) is a scale of 14 positively worded items, with five response categories, for assessing a population´s mental wellbeing. Warwick and Edinburgh Universities were commissioned to develop it in 2006. Assessing the mental wellbeing (positive mental health) of the population requires validated scales that reflect current concepts of mental wellbeing. The adult mental health indicators work highlighted the fact that there is a need for such scales which capture current thinking and which are validated for use in Scotland and elsewhere in the UK. http://www.healthscotland.com/scotlands-health/population/measuring-positive-mental-health.aspx

Mixed Methods Analysis

Analysis of quantitative data

The data were exported to SPSS, R statistical programme and ArcGIS for statistical investigation. Descriptive analysis, including bivariate association, was conducted to show relationships between variables of interest. T-tests and chi square tests of association were used in the first instance to identify variables which were significantly ($p < .05$) different; variables which were found to be statistically different were investigated further through geographical mapping and clustered bar graphs.

The quantitative analysis focused on the following four core elements:

1. **Descriptive statistics** for the sample as a whole (age, gender, geographical location).
2. Cross-referencing **respondent characteristics** (e.g. age, geographical location, income, occupation, whether or not they felt geographically remote, i.e. QUS.2-12) with their self-reported mental health issues, and with their responses about transport, remoteness, service use, community support and where they turn to for help.
3. Cross-referencing **respondents' self-reported conditions** with their other responses, including: public transport use; geographical remoteness; community support; and who they turned to for help.
4. **Unpacking questionnaire Section III which has "community" as its focus**: specifically examining the role and importance of community in providing support for people experiencing mental ill health. Questions related to whether respondents felt they lived in a supportive community, could rely on members of their community to assist them with their mental ill health, who they turned to for help with their mental health issues, whether they met and socialised with others with mental ill health in their community, and whether they felt they could be open about their mental health problems in their community.

Analysis of qualitative data

The survey contained five open-ended questions which generated textual (qualitative) responses:

- Advantages and disadvantages of living in a geographically remote area (QU.19)
- Good and bad things about where you live (QU.20)
- If you could change ONE THING about mental health services in rural Scotland, what would that be and why? (QU.30a)
- What KEY MESSAGE do you want to tell policymakers to help you manage your mental ill health in a rural setting? (QU.30b)
- If you could change ONE THING about your life in rural Scotland, what would it be and why? (QU.30c)

A **thematic analysis approach**[5] was used, and was applied in three ways:

1. *Within* each of the five open-ended questions, responses were grouped into those themes which emerged through the analysis.
2. Qualitative responses from each of the questions were *cross-referenced* with respondent characteristics, such as gender, age and geographic location, to identify any observable patterns between responses and their links to characteristics.
3. Respondents' *self-reported mental health issues* were then cross-referenced with their qualitative responses, again to identify any patterns.

[5] Patton, M.Q. (2014), *Qualitative Research & Evaluation Methods: Integrating Theory and Practice*, London: Sage Publications.

Key findings

1. Characteristics of the survey sample

1.1. Number and geographical distribution of survey respondents

The survey generated 343 responses from people experiencing mental ill health across rural Scotland. Respondents gave the first half of their postcode as a geographical identifier, which enabled mapping of respondents' locations, from the islands in the north and west through to the south west and south east mainland (Figs. 4 and 5). There were gaps in coverage in the central highlands of Scotland and along the northern coast. Nonetheless, this response rate and distribution has given us a valuable insight into how people are living with their mental ill health across accessible and remote rural Scotland.

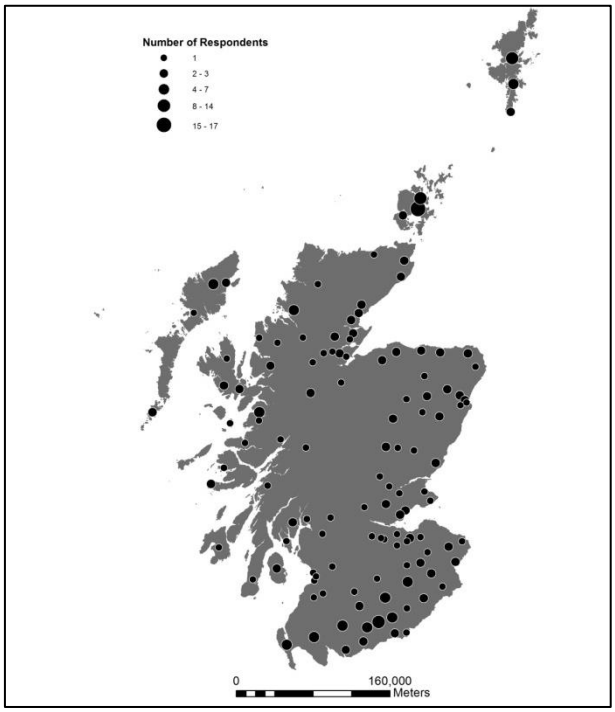

Figure 4: Location of respondents

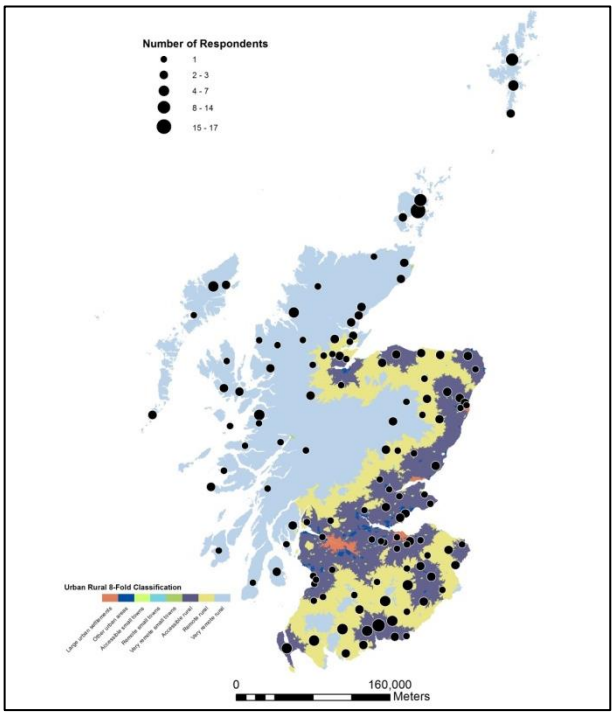

Figure 5: Respondents' location overlain with Scottish Government's 8-fold Urban-Rural Classification

Figures 4 and 5 contain OS data © Crown copyright and database right (2017).

1.2. Gender and age of survey respondents

The majority of respondents are female (273), with the remaining respondents being male (70) (Fig.6). Both SRUC and SiMS were delighted with the number of responses from males, as this is a typically under-represented group in terms of disclosing feelings and concerns about their mental ill health. Due to the number of males responding therefore, we were then able to unpack evidence from males in relation to their self-reported conditions and their open-ended responses (see below for both).

The age-spread of responses was similar within both male and female categories, with the majority coming from the 45-54 age cohort. We noted only a small number of responses from those aged 65+ (less than 15), and we speculate that this is because the main medium for responding to the survey was online, although an offline option was available. Conversely, we noted almost 50 responses coming from those aged 16-24, and this has given us a valuable set of evidence around the experiences of young people with mental ill health in Scotland's rural areas.

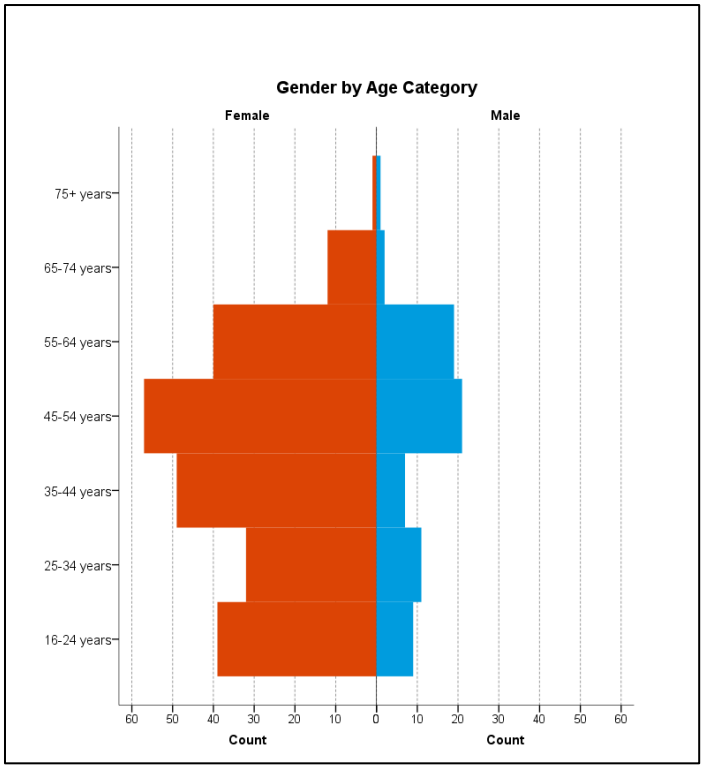

Figure 6: Age and gender of survey respondents

1.3. Employment status and occupations of survey respondents

The majority of our survey sample (214) are in paid employment, self-employed or on government training, with 37 unable to work and 27 in full time education (Fig.7)[6]. This profile of respondents is unusual, in that the typical client for Support in Mind Scotland, and for similar mental health charities whose main function is outreach, support and service provision, are those who are unable to work due to their mental health condition(s). The rural survey has therefore generated useful data in terms of those who are in paid employment who are also experiencing mental ill health challenges, as well as for those who remain unable to work.

The occupations were self-reported by the respondent[7], rather than being pre-categorised in the questionnaire, in order to maximise the freedom to describe the type of work being done. The distribution of categories within the sample show the majority in financial/business/office management, and health and social care, with 17 coming from agriculture and related businesses (Fig.8). Respondents specified that they work in health and social care, education, and public

[6] 305 of the 343 survey respondents chose to give their occupational status.
[7] 201 survey respondents specified an occupation, with 142 respondents giving no response.

sector/government; if we were to group these together, they could form the largest group as 'public sector' – however, respondents chose to describe themselves in these sub-categories, and we therefore cannot be totally certain that all those who reported working in health, social care and education were in the *public* sector, hence reporting them separately.

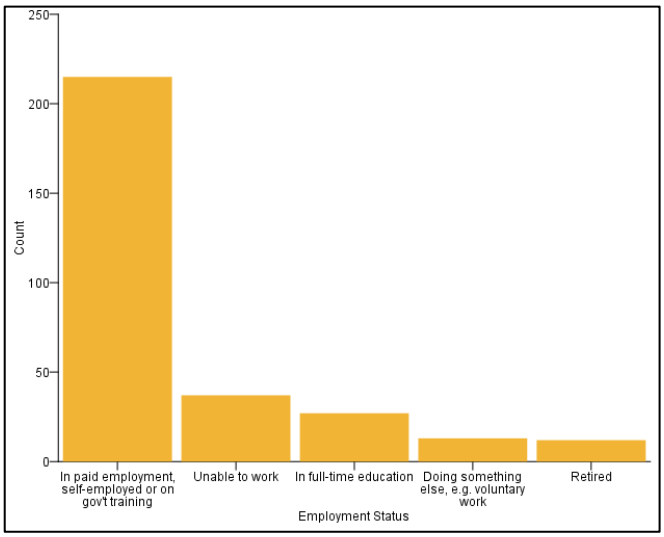

Figure 7: Respondents' employment status (n=305)

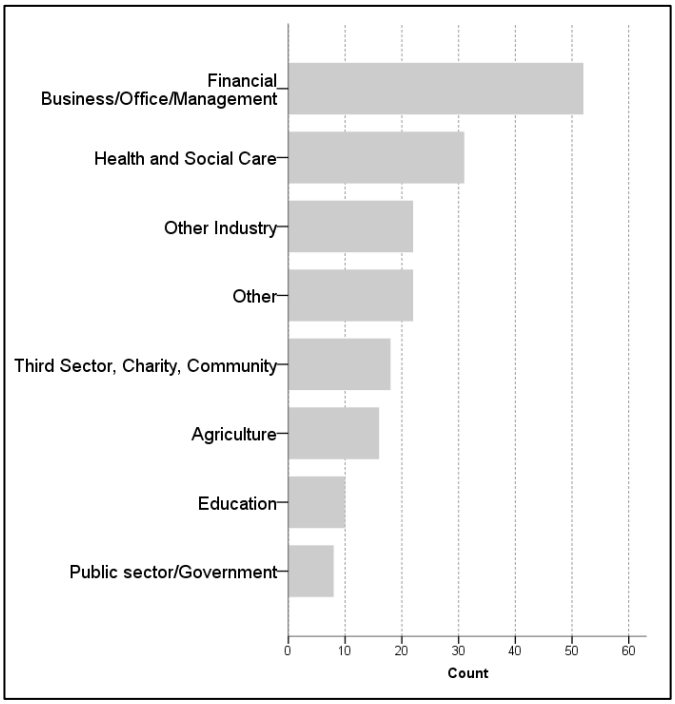

Figure 8: Respondents' occupation category (n=201)

In addition to the survey sample generating data about the experiences of those who are employed whilst also experiencing mental ill health, the data also enabled us to draw correlations between employment status and respondent's position on the Warwick-Edinburgh Mental Wellbeing Scale (Fig.9). The picture shown below is perhaps as would be expected: that 50% of those unable to work have a Very Low score with a further 30% below average; this is in contrast to those who are in paid employment, where approximately 10% are in the Very Low category, with a similar percentage Above Average. Similarly, for those who are "doing something else e.g. voluntary work", over 20% have Above Average scores on the scale. It is also worth noting that almost one third of those in full time education have Very Low scores.

Whilst fully recognising this more expected picture, it is also interesting to note that those in employment also reported mental health issues including suicidal thoughts and feelings, self-harm, depression and anxiety. This means that the evidence from the rural survey is pointing to a more complex and nuanced picture of mental health for those in employment in rural Scotland – something we return to later in the report.

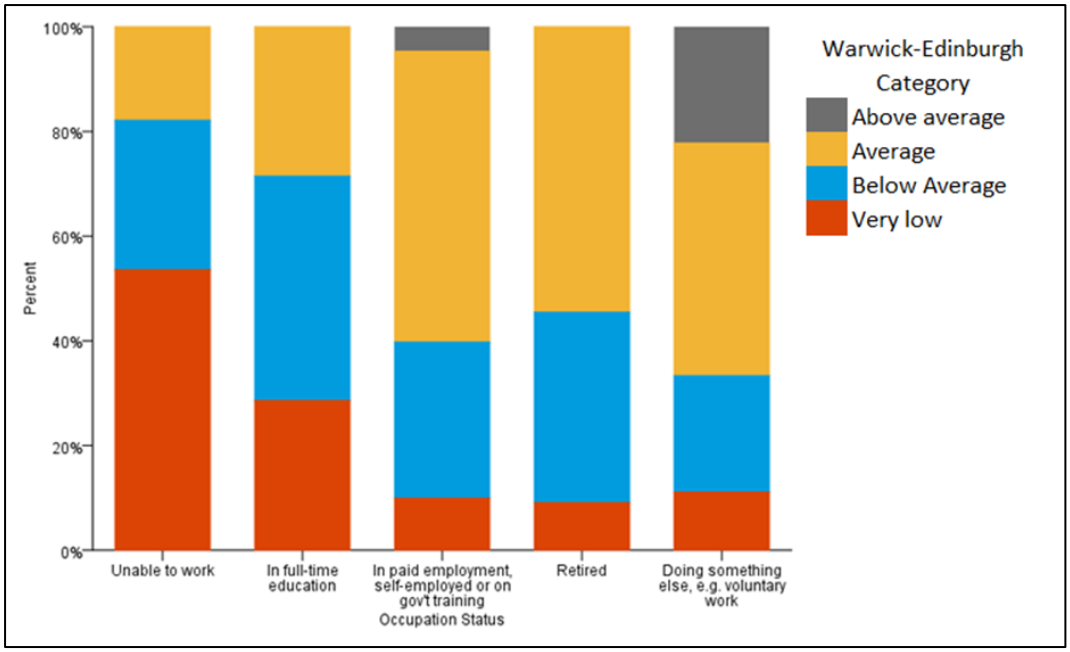

Figure 9: Correlation between occupational status and mental wellbeing according to self-reported responses to the Warwick-Edinburgh Scale 14 statements

2. Respondents' self-reported mental wellbeing

2.1. Introduction

Respondents were asked to indicate their mental wellbeing through two main ways. Firstly, by giving their scores on the **Warwick-Edinburgh Mental Wellbeing Scale** (see above) to 14 positively-worded items (such as "I've been feeling optimistic about the future", "I've been thinking clearly") with five response categories (from "None of the time" to "All of the time") which are validated for use in Scotland. Secondly, by self-reporting whether they currently had any of **15 recognised mental health issues**; they could respond to as few or as many as they felt were relevant to them. The 15 conditions listed in the survey were:

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

2.2. Survey responses to the Warwick-Edinburgh Mental Well-being Scale

The two figures below give the distributions of the SRUC/SiMS rural mental health survey responses (Fig.10) and the profile from the National Health Survey 2014 (Fig. 11) for comparison. What this shows is that the difference between the SRUC/SiMS *rural survey* responses and the Scottish Health Survey *national average* score is 10 points, which is significant.

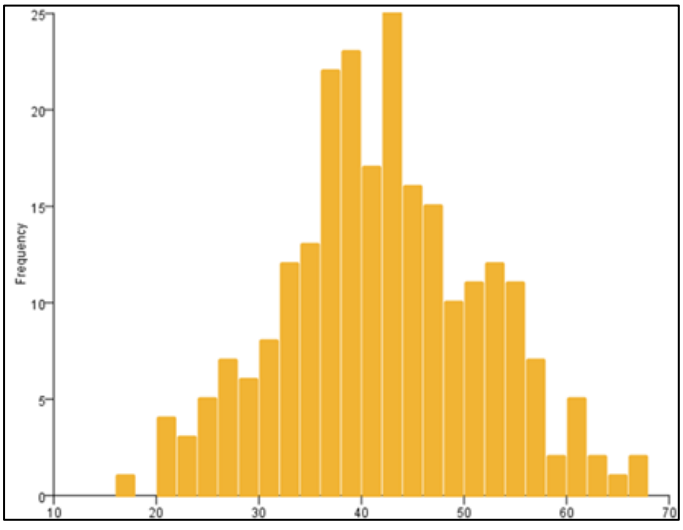

Figure 10: SRUC/SiMS survey; average score = 40

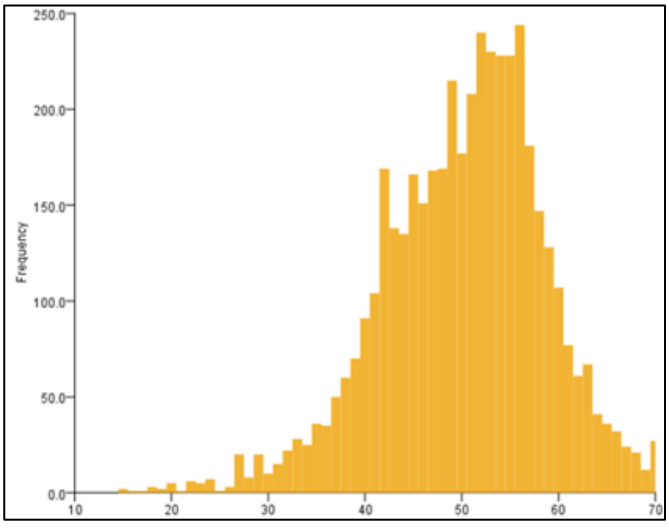

Figure 11: Scottish Health Survey (2014); average score = 50

2.3. Respondents' self-reported mental health issues: geographical distribution

There are three main points to note (Table 1):

1. The highest number of survey respondents came from the **Dumfries and Galloway** postcode area (62), with proportionately high levels of responses also from Highlands and Moray, Highlands and Orkney Islands, with Perthshire and Shetland Islands collectively showing strong response levels.
2. When looking at the **regional responses per self-reported mental health issue**, it is important to be aware that although the highest numbers of issues are reported in Dumfries and Galloway, this is simply because this postcode region is where the highest numbers of respondents came from; i.e. it does not mean that more people are depressed in Dumfries and Galloway than, say, the Scottish Borders.
3. When looking at the total numbers of respondents self-reporting the top five mental health issues, we note that **197 people reported depression** (67% of the sample), **87 people reported generalised anxiety disorder** (29%), **64 people reported suicidal thoughts and feelings** (22%), **53 people reported social anxiety disorder** (18%) with **35 reporting self-harming behaviour** (12%). This was during the four-week period of August-September 2016, which is potentially of significance, since anecdotal evidence points to the fact that some mental health issues, such as depression, are worsened during the winter months, particularly in northern areas, due to shorter daylight hours.

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

Table 1: Geographical distribution of respondents' self-reported mental health issues by postcode area. (296 shows the number of the total 343 respondents who chose to give the first part of their postcode as a location identifier).

Figure 12 shows the geographical distribution of respondents' mental health issues according to local authority area. Each of the vertical bars represents one of the top five self-reported mental health issues. The size of the graphs in each local authority area reflects the numbers of respondents in that local authority area. What is interesting to note is that the pattern of each of the graphs is very similar, irrespective of geographical location, with depression being the most frequently reported mental health issue.

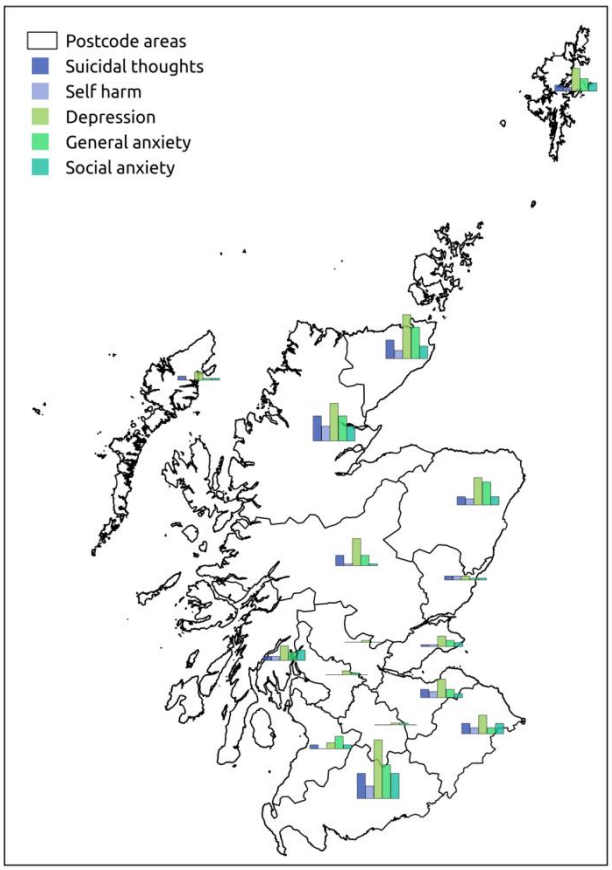

Figure 12: Map showing the geographical distribution of self-reported mental health issues by respondents, by local authority area. Contains OS data © Crown copyright and database right (2017)

2.4. Respondents' self-reported mental health issues: by gender

As noted above, the majority of respondents to the survey were female (273), with 70 male respondents. However, *within* the categories of men and women, the *percentages* of those self-reporting the 15 mental health conditions were very close (Fig.13). What this means is that *similar proportions* of male and female respondents were reporting depression, generalised anxiety disorder and suicidal thoughts and feelings (identical). This raises two key points: firstly, that women are reporting proportionately as much of these conditions as men, whereas anecdotally conditions such as depression and suicide are seen as "male", particularly in a farming context. Secondly, there are high proportions of men reporting these conditions, when typically men are not open and are known, again anecdotally, for not talking about these issues. So, in both instances, the data from the survey are throwing light on the fact that the picture is more complex than the anecdotal evidence would suggest for respondents in rural Scotland. It is also worth noting that 50% of the females who

answered the survey, and almost 50% of the males, reported depression during the four-week period of the survey taking place, with 22% of both men and women reporting suicidal thoughts and feelings – a total of 64 people – at the time of responding to the survey in August/September 2016.

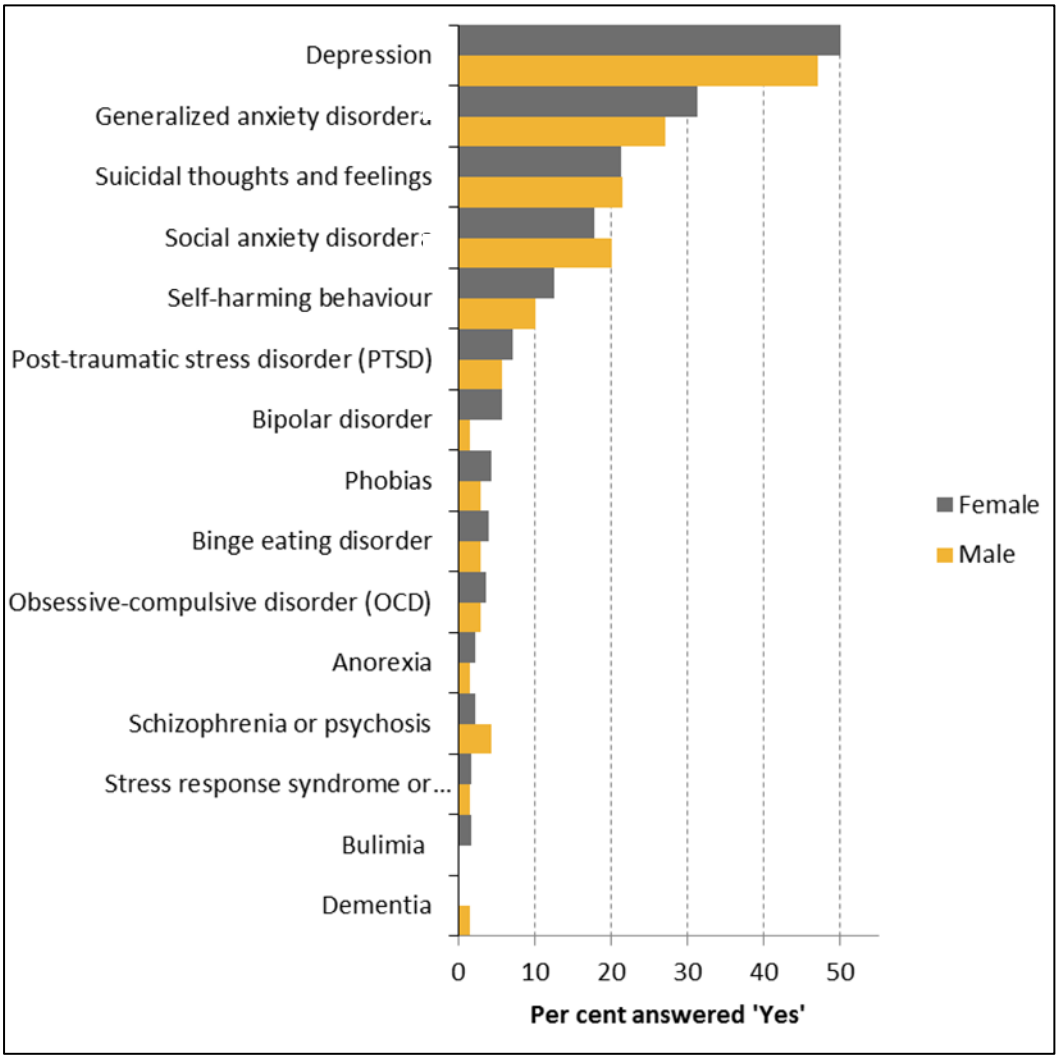

Figure 13: Percentage of males and females who answered "yes" to the 15 mental ill health conditions

2.5. Respondents' self-reported mental health issues: by age

Overall, there is no stand-out pattern to the most frequently self-reported issues and their relationship with respondent's age (Fig.14). This is an important finding, since again, anecdotally, the picture might typically be that self-harming is associated with younger people and depression and suicidal thoughts with older people. However, the data from the rural respondents show this not to be the case. Approximately 40% of those reporting self-harming behaviour were aged under 24 with approximately 30% being aged 45 or over. Suicidal thoughts and feelings were reported more by those aged over 45 (almost 40% of responses came from this age cohort), although it is also important to note that almost 30% of responses came from those aged under 24. Depression was also reported mostly by those aged over 45 (almost 50% of those reporting this mental health issue), although one-fifth of responses also came from those aged under 24. Although 40% of those reporting self-harming behaviour were under 24, almost one third of those reporting this were aged

over 45. What these findings show, therefore, is that these issues are being self-reported across age cohorts by the survey respondents in rural Scotland.

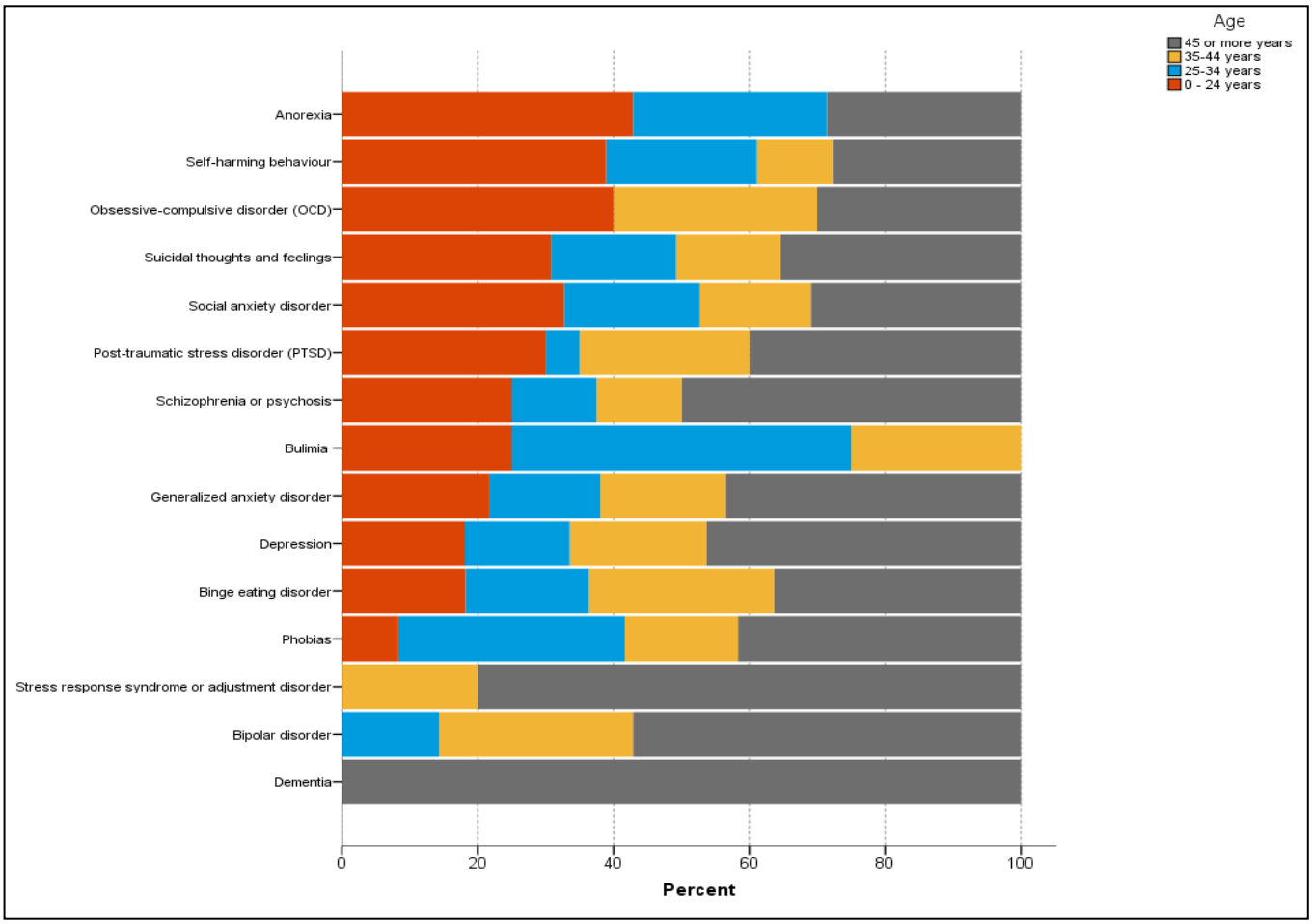

Figure 14: The age distribution of responses for each self-reported mental health issue

2.6. Respondents' self-reported mental health issues: other respondent characteristics

For this next series of graphs, it is really important to note that their key purpose is to observe and compare *patterns* when looking at two graphs side-by-side. It must be noted that the graphs represent numbers of respondents. Therefore, when comparing one graph with another, we are *not* looking at the difference in absolute numbers, but rather whether *patterns are similar or different* between the two graphs. This will become clear in the figures below (Figs. 15 to 18).

The Figures do not have individual commentaries, since they are not intended to present conclusive pictures or theories. Rather, their aim is to generate thoughts and questions as to what might be behind these patterns or differences, and to identify possible directions for further inquiry or action.

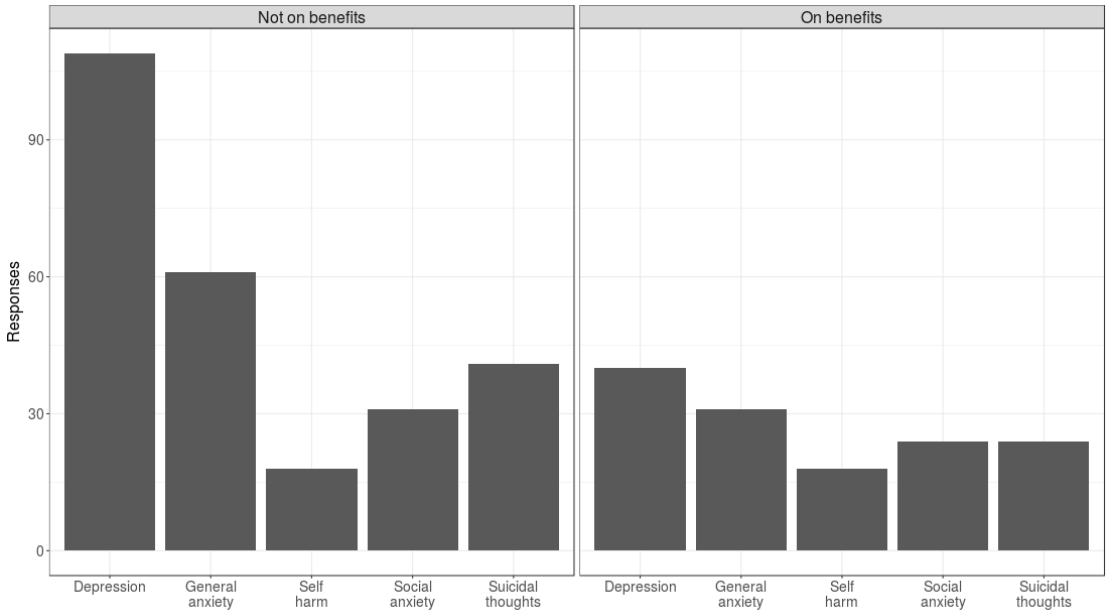

Figure 15: Whether on benefits and self-reported mental health issues

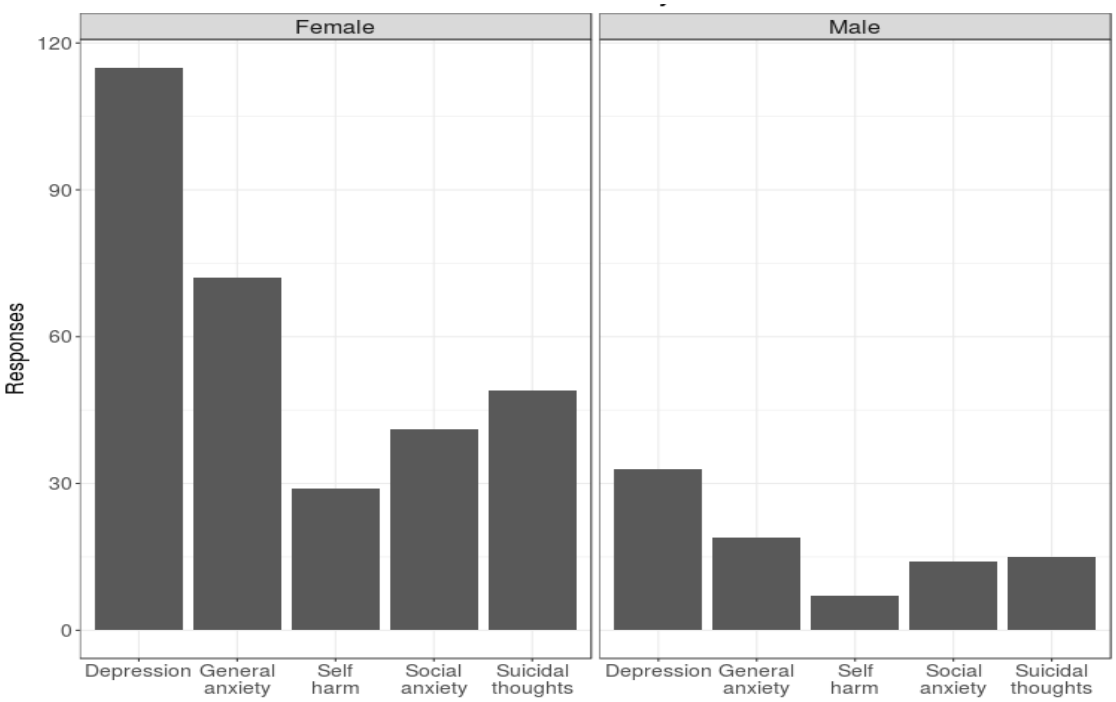

Figure 16: Gender and self-reported mental health issues

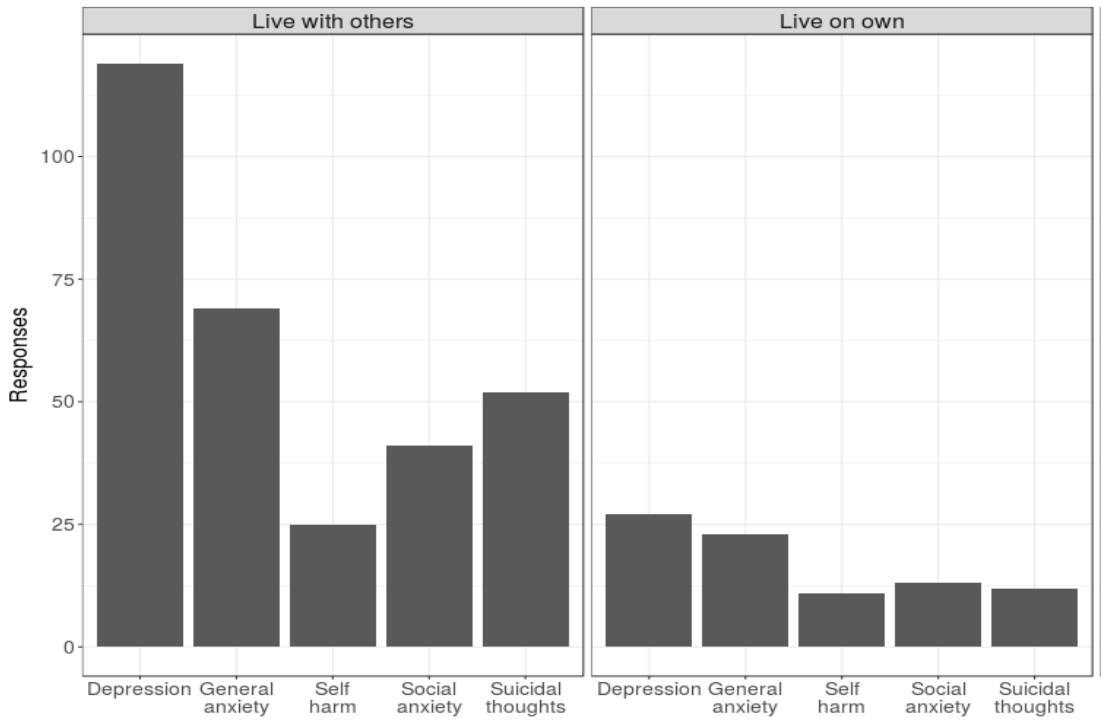

Figure 17: Whether live on own and self-reported mental health issues

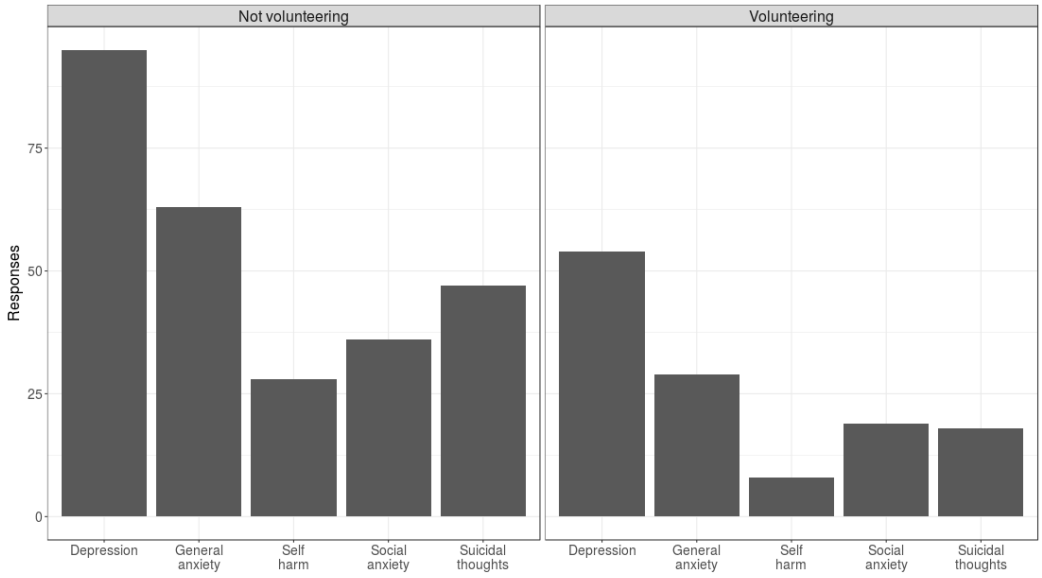

Figure 18: Whether volunteer and self-reported mental health issues

3. Survey respondent's geographical location and any associated barriers

3.1. Correlation between respondents' perception of geographical remoteness and their Warwick-Edinburgh Wellbeing Scores

We examined respondents' *perception* of geographical remoteness alongside their responses to the 14 positive statements in the Warwick-Edinburgh Mental Wellbeing Scale (Fig.19). Interestingly, 50% of those who consider themselves to live in a geographically remote area score Average or Above Average in the Warwick-Edinburgh Scale, compared with 40% of those who do not consider themselves to live in a remote area. These findings can also be explored alongside those which set out the range of responses concerning the importance and a "supportive community" to those experiencing mental ill health (see Section 4 below).

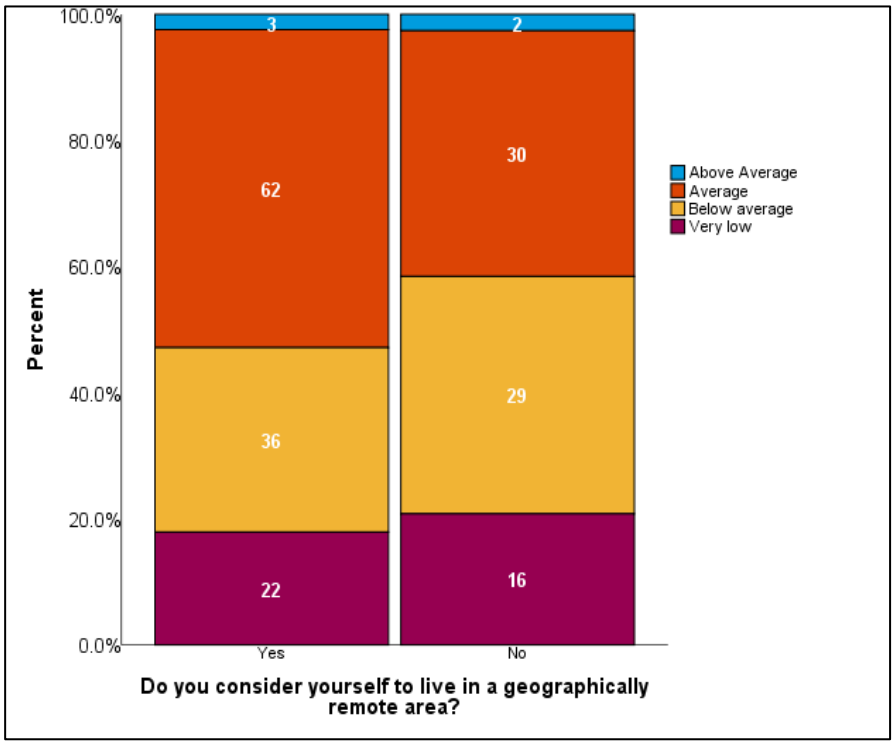

Figure 19: Respondents' perceptions of geographical remoteness correlated with scores on the Warwick-Edinburgh Mental Wellbeing Scale

3.2. Respondent's geographical location versus perceived geographical remoteness

As shown above (Section 1), we were able to map a respondent's location based on their submission of the first part of their postcode (e.g. KW14 or TD11). This enabled us to compare a respondent's *actual* geographical location with their perceived geographical remoteness, through their response to the question*: In your opinion, do you consider yourself to live in a geographically remote area?*

The analysis of the survey data (see Fig.20) shows that there is no clear link between a respondent's *actual* geographical remoteness and their *perceived* geographical remoteness, *except* in the case of those respondents who live in areas classified as "Remote Rural" according to the Scottish

Government's six-fold Urban-Rural Classification[8]. For example, over half of those respondents who live in Accessible small towns also consider themselves as geographically remote, as do 80% of those living in Remote small towns and 50% of those respondents living in Accessible rural Scotland.

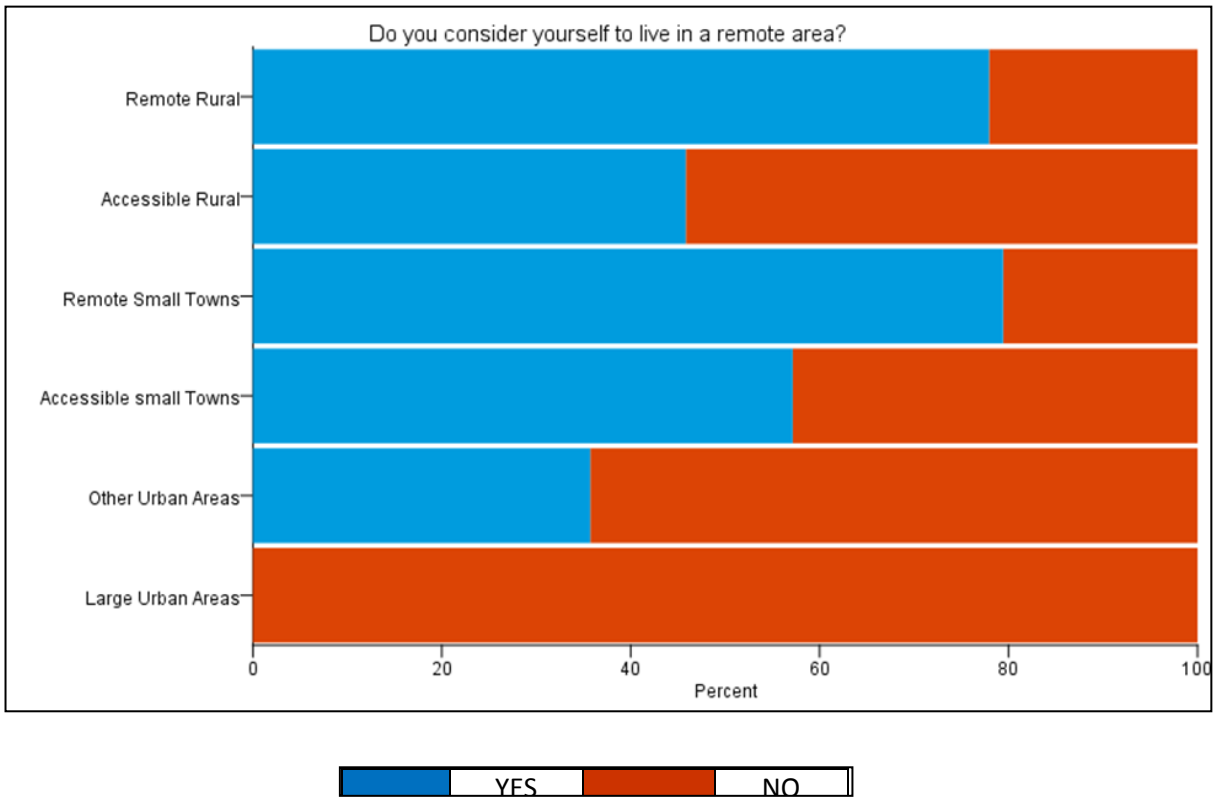

Figure 20: Correlation (showing percentage of respondents) between *perceived* geographical remoteness and postcode-based geographical location, categorised using the Scottish Government's six-fold Urban-Rural Classification. Note that those living in "Large Urban Areas" comprise those who gave their postcode as (for example), DG1 (Dumfries), IV1 (Inverness), thus indicating that they live within the postcode area of Dumfries or Inverness. This was a small proportion of the sample, however.

3.3. Remoteness in relation to access to mental health facilities

In order to explore how distance and remoteness "played out" in relation to access to mental health facilities, we asked specific questions about distance to nearest mental health facility and the extent to which public transport acted as a barrier to accessing the proper care needed to manage respondent's mental health. These questions were focused on the individuals responding, that is, "managing *your* mental health", rather than asking them to reflect for people in rural areas more widely.

The findings show that, for the majority of those responding to this question, transport for a journey of more than 10 minutes' drive time was required to reach a mental health facility (Fig.21), with over 100 respondents stating that public transport *often acted as a barrier* to them receiving proper care needed to manage their mental health (Fig 22).

[8] http://www.gov.scot/Topics/Statistics/About/Methodology/UrbanRuralClassification

We then examined whether there were any links between the top five self-reported mental health issues and public transport access for managing mental ill health (Fig. 23). We found that, for those self-reporting **suicidal thoughts and feelings**, more than double stated that public transport *did* act as a barrier than those who stated it did not. For those self-reporting **self-harming behaviour**, three times the number of people stated public transport was a barrier than those stating it was not. It is possible to infer that any perception of geographical remoteness, coupled with these barriers of accessing mental health care via public transport, can lead to a "layering" of remoteness and isolation for people experiencing mental ill health in rural areas.

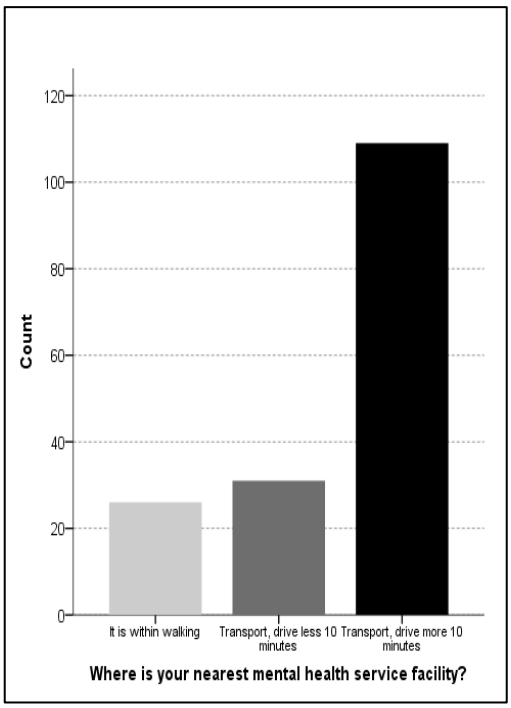

Figure 21: Distance to nearest mental health facility

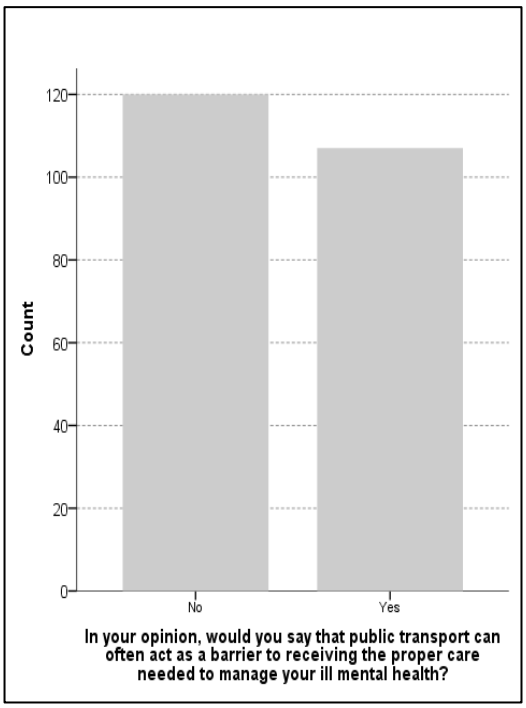

Figure 22: Public transport as a barrier

		In your opinion, would you say that public transport can often act as a barrier to receiving the proper care needed to manage your ill mental health?	
		No	Yes
Mental Ill-Health Conditions	Suicidal thoughts and feelings	18	43
	Self-harming behaviour	8	25
	Generalized anxiety disorder	44	45
	Social anxiety disorder	21	30
	Depression	67	75

Numbers represent respondent counts

Figure 23: Public transport as a barrier for those with specific self-reported mental health issues

3.4. Postcode analysis: open-ended responses to the survey questions

Respondents were asked to give the first part of their postcode in order to enable us to map their approximate location; we did not ask for complete postcodes since maintaining anonymity was of prime importance in the survey, and in rural areas a complete postcode can give the precise location of a single house, farm, business or small group of houses. Of the 343 responses received, 296 respondents chose to give the first part of their postcode (Appendix 2 shows the 94 postcode areas).

The open-ended responses to the two questions relating to (i) desired changes to rural mental health services and (ii) a key message for policy makers in relation to rural mental health in Scotland, were then sorted according to postcode area, to identify any patterns in responses.

Although it was not possible to identify clear patterns in the data, there is still value in seeing the findings from different postcode areas. These are therefore grouped below as bullet points under their respective postcode areas, with island issues shown separately (Tables 2 and 3).

Question: If you could change ONE THING about mental health services in rural Scotland, what would that be and why?	
Postcode areas	**Responses/themes**

Aberdeenshire (AB21-AB56)	• **Impact of the community – positive and negative:**
	  ○ The community can help people stay well – build community capacity.
	  ○ Attitudes in mental health are worse out there in the community, it harms and hurt people who live with mental health issues.
	• **Work to reduce stigma:**
	  ○ I would work to raise awareness around mental health and make it as normal. Disease like diabetes or cancer.
	  ○ Less stigma.
	  ○ Helping everyone understand that everyone has (mental health) problems.
	• **Improve access:**
	  ○ Better access to psychological support.
	  ○ Tailored support.
	  ○ More qualified people in area.
	  ○ Someone qualified in each local GP health centre or cottage hospital.

Dumfries and Galloway (DG1-DG16)	• **Consistent help and access:**
	  ○ Make it fully part of the NHS not a bolt-on, hidden part of the NHS.
	  ○ Better GP understanding of mental health problems and better referral to specialist help.
	  ○ Shorter waiting times.
	  ○ Quicker referral from GP to specialist.
	• **Support for:**
	  ○ adults with anxiety.
	  ○ young people and people with low incomes.
	  ○ people with complex needs .
	  ○ those discharged from hospital should NEVER feel that they have been left alone to get on with things and they should be encouraged to go along to some groups etc. to see if they like it.
	• **Therapies that are not drugs-based:**
	  ○ More work that reduces the stigma around talking, so that

	people can start to improve their mental health at home and in their communities. o Easier to access therapies that are not drug-based. o More access to alternatives to drug therapy. • **More outreach services:** o Improved contact with services from town. More visits/ support/ so basically more outreach facility to increase contact with services. o Throughout the region. o More publicity is essential to publicise facilities and illnesses more.
Highland and Moray (IV2-IV63; PH26-PH50)	• **Reduce waiting lists:** o Waiting list for my appt at new Craigs hospital, over 18 months now. Worry is the doctors haven't contacted to see if I am ok. I've struggled badly but determined it won't beat me. Others may not be so strong. o Shorten the waiting time to see a psychologist. Last time I asked it was 18 months so I just gave up! • **Create more local support groups:** o More local support groups. o It's really difficult in a rural area, but I don't know of any crisis centres near where I live even though suicide rates are high among young men. o Better accessibility at a grassroots level in the community. o More funding to support local initiatives. o Services being creative about how to get out into rural communities. o Provide more support locally rather than in centres such as Inverness, more outreach services. o Closer to resources. Nearest CAMHS is over 214 round trip, nightmare on public transport. • **Specific support needed for:** o women with mental health issues. o easier access in a neutral discreet place.
South and East Ayrshire (KA6-KA19)	• Look at real reasons why there are so many problems • The need to access decent psychologists and psychiatrists. Rather than just one and if they don't work well with you then tough sh*t. • **Easier access:** o Easier access to mental health facilities and a 24 hour service at medical practices. o Have services in community hubs rather the towns and cities.
Fife (KY2-KY10)	• **Outreach and education:** o Having a resource bus that could visit all the villages where people could go to get more information that is accurate, make a self-referral for help, find out about local support groups, speak to trained medical staff. o Educate the staff to be less judgemental, introduce more compassion.
Argyllshire (PA23-PA24)	• **Access to:** o Good crisis response. o Self-referral. o Talking therapies.

Perthshire (PH1-PH11)	• Travelling services, use of local village halls, school etc. • Better and more support for people with addictions, we need more therapists. • More information and advertising about what is available.

Scottish Borders (TD2-TD12)	• **Crisis:**
	  ○ More facilities BEFORE crisis stage.
	  ○ Mental health is about more than being in crisis.
	• More education for general public, to reduce stigma.
	• Use skills in community to increase access to support and help.

RESPONDENT VIEWS FROM THE ISLANDS	
Isle of Lewis and Isle of Barra	• Make psychological therapies more widely available. • More mental health services - let it constantly be advertised to make people aware of mental health and to become more accepting and for others not hide away because of their ill mental health.
Isle of Skye	• More inclusive service for women with mental health issues. • Easier access in a neutral, discreet place. • More facilities/staff for services. • Access to a CPN on a consistent basis.

Orkney Islands	• **More resources and funding:**
	  ○ More visible support with more professionals available.
	  ○ Waiting lists too long.
	  ○ Local support rather than having to travel to "foreign environment" which adds to people's stress.
	  ○ Respite centre needed.
	• **Pre-crisis:**
	  ○ At moment, services only for high-risk situations.
	  ○ More mental health specialists/professionals and psychiatrists needed because there are increasingly more young people with worsening mental health conditions.
	  ○ GPs need to be more willing to look for an underlying condition instead of handing out anti-depressants.

Isles of Islay and Mull	• To have more facilities, resources and professionals full time on the island. • Being able to access CPN by Skype or equivalent.

Shetland Isles	• **Waiting times to access professionals:**
	  ○ Appointments can take up to 9 months.
	  ○ More out-reach support; reduce waiting list times.
	  ○ Equal facilities with less remote areas.
	• **Young people:**
	  ○ More drop-in services with trained staff in Youth Clubs and more open discussions and group meeting points for people affected with mental health issues.
	  ○ There needs to be more support given to communities in tackling issues and there needs to be more awareness and A LOT more support offered to young people in schools.

Table 2: Respondents' suggested changes to rural mental health services, grouped according to postcode

Question: What KEY MESSAGE do you want to tell policy-makers to help you manage your mental ill health in a rural setting?	
Postcode areas	**Responses/themes**

Aberdeenshire (AB21-AB56)	• **Isolation:**
	  ○ Mental health is just as much a function of loneliness and social isolation.
	  ○ Poor broadband makes one isolated.
	  ○ Not everyone can drive or has the ability to use bus services which are not that frequent in rural areas.
	  ○ Improve access to help - whether that is access as in opening village hall for tea and chat or bus service to health services.
	• **Investment is needed:**
	  ○ People with mental ill health live in country areas. But mental health is very poorly resourced and co-ordinated. Why is it not more like mainstream medicine? It SHOULD be.
	  ○ Invest in mental health support or the problem will get worse.
	  ○ Take mental health seriously...it can be life threatening.
	• **Training:**
	  ○ Invest more in training and development of staff, GPs and nurses – in large sectors of our communities, even healthcare providers are not very much aware of the mental health issues.
	  ○ Public services should be fully aware of the mental health issues of people and how to help and support.
	  ○ Need more competent mental health practitioners.

Dumfries and Galloway (DG1-DG13)	• **Person-centred approach:**
	  ○ It is an invisible illness and every person is different in their journey.
	  ○ Think about the person not the condition.
	  ○ Try and cater to all aspects of mental health issues.
	  ○ Need more and flexible range of services to meet individual's needs.
	  ○ Be taken seriously: Don't tell me that as I have a nice view I must be feeling better!!!!
	• **Isolation aggravates mental illness:**
	  ○ Create accessible mental health services and treatments designed for rural areas, e.g. portable mental health clinics and support groups; more outreach support for families.
	  ○ Support various community initiatives that bring people together as a community.
	  ○ Develop strong community hubs with free drop-ins and bus waiting areas!! and public transport systems for them to be accessed.
	  ○ If home visiting is too costly then regular contact via phone or internet would be very helpful - just to know someone is there for you.
	• **Listen to people with mental health issues:**
	  ○ Find a way to have a meaningful dialogue with people with mental health issues. More often than not, they will tell you the best way to help them manage their condition. Listen. Listen. Listen

Highlands and Moray (IV2-IV63; PH26-PH50)	• **Services:**
	  ○ Need to be proactive and encourage people to use them.
	  ○ Services need to be protected – frontline AND projects and services that help people stay mentally well and healthy like arts projects and social farming projects etc.

	○ Earlier intervention/prevention needed. ○ Smarter use of technologies to aid consultation. ○ Enable people who work during the day to access services. • **Loneliness especially in winter** (Seasonal Affective Disorder): ○ Realise that isolation is a huge factor in poor mental health - transport difficulties can be solved. ○ Support community transport to help get people there. ○ Good communication and good public transport really help • **Parity:** ○ treat people with mental health problems the same as people with other physical health problems. • **Listen to service users:** ○ Listen to those who are in crisis or have faced a challenge. ○ Be flexible about needs and listen to people.
South and East Ayrshire (KA6-KA8)	• **Localised services:** ○ More buses to large 'distribution centre' hospitals does not provide better care for mental health patients. Providing real services in small communities, by innovative means if necessary, is more likely to have a positive outcome. Use what is on your doorstep. Not all care has to be the same.
Fife (K2-KY14)	• **Crisis houses and counselling support:** ○ so people can get 24/7 support outwith the hospital environment. ○ have a counsellor available for a drop in clinic say 2-3 times a week or CPN.
Argyllshire (PA23-34)	• Mental illness seen as equal to physical illness. • Better provision of talking therapies. • **Stress of travel:** ○ Travelling to distant appointments with limited choice of appointment times is not helpful for recovery. ○ Stress of travelling to appointments (especially in winter, or when the Rothesay ferry was going into Gourock) takes a long time.
Scottish Borders (TD6-TD12)	• **Pre-crisis services for young people:** ○ Provide more mental health services that meet young peoples' needs and not just for a crisis. Youth work services are dealing with the fall out and we are not equipped to handle specialist mental health work.
RESPONDENT VIEWS FROM THE ISLANDS	
Isle of Lewis and Isle of Barra	• More therapists working in NHS. • You obviously can't change people's minds, but try harder to show that mental health is something to be taken seriously.
Isle of Skye	• **Education about mental health:** ○ Education needs to begin at an early age to accept mental ill health as an illness the same as any other physical illness not a weakness or something to be ashamed of or fear. • **Services on the island:** ○ Increase number of key workers. ○ More staff for services. ○ Psychological support services are lacking and much needed.
Isle of Arran	• Do not disadvantage remote and rural populations.
Orkney Islands	• **Funding and services:**

	○ More funding required. ○ Desperately need more psychiatrists/mental health specialists … help specific mental health conditions. ○ GPs need to come on board. ○ Innovation and creativity is essential for tackling this issue. ○ Offering support strategies such as counselling; CBT; mindfulness etc. at an early stage. ○ Having difficulty expressing issues, being able to do this in a way which is not face to face with someone you are likely to bump into in town, would give a freedom to express and explain exact feelings and fears. • **Publicity:** ○ More publications about mental health to encourage people to come forward. ○ Make it more easily accessed and people more aware of community services. ○ Knowing that you're not alone and many others suffer too. Make it easier for people to talk to each other i.e. support groups. ○ Community transport can be vital for people with mental health issues. • **Online:** ○ Online services so that people don't feel isolated. ○ Offering support which is available on line, via email etc. • **Employees:** ○ Better training for managers to help employees
Shetland Islands	• **Investment needed:** ○ Not enough investment in resources or practises. ○ Fund local groups who help. ○ The current waiting time is dangerous, anyone who is having to wait a significant amount of time to be seen will be at a greater risk for self-harm or suicide. ○ It takes too long to see someone - what is the point in trying to access any help if you have to wait months and months? ○ A LOT more funding should be put into 3rd sector Organisations who work directly with other adults and young children. Funding should not be directly given to Councils when there are charity Organisations and independent Youth and community Centers willing to offer a service asked by the community. ○ More facilities and equal importance as physical illnesses. • **Local support:** ○ Make sure people have proper follow up when they are discharged from Aberdeen. • **Online:** ○ There is too much relying on yourself having to go online to deal with self-help schemes and to speak to people on the phone

Table 3: Respondents' key messages for policy makers in relation to rural mental health in Scotland, grouped according to postcode

4. Community support and connections

4.1. Introduction

"Community" is experienced in many different ways by survey respondents. For some, it evokes the following words and phrases: good banter; supportive and close; smaller, personal community; strong community links; familiar; close community; close friends; caring community; feeling safe, home. For others, their experience of community is described as: nosy; judgemental; lack of privacy; parochial attitudes; everyone knows everyone's business; embarrassing when people know you're too ill to work; and small communities are not the best to talk about your mental health issues. In this sub-section of the report, we look firstly at the quantitative data which further illustrates this mix of responses around community, secondly examine who people turn to for support, and thirdly explore how respondents have described their experience of community in their own words.

4.2. Supportive community and openness about mental health problems

In this series of community-focused questions, we firstly asked whether the respondents felt they lived in a supportive community. Although just under 40 of those who answered this question said that their community is "completely supportive" of them, which is obviously positive, more than three times that number of respondents said either that they "could get some help but they could help me some more" or that "no my community is not supportive of me" (Fig.24).

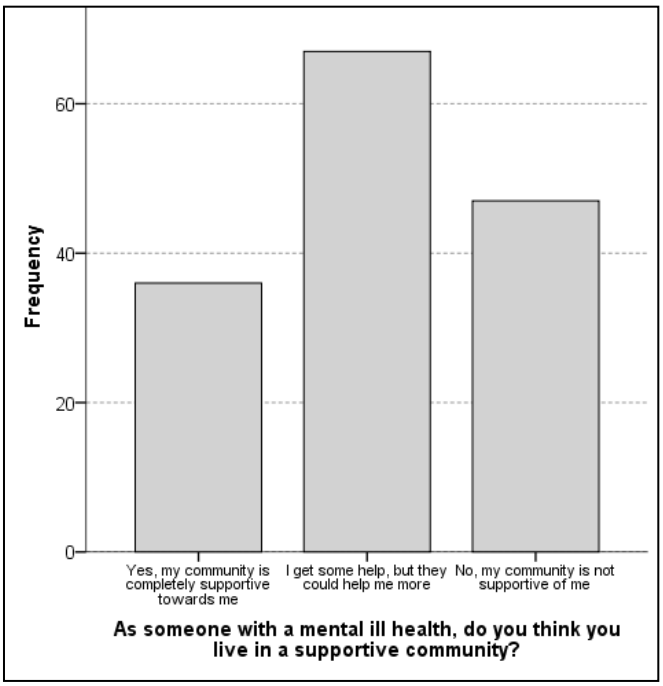

Figure 24: Number of respondents answering three options relating to degrees of "supportive community"

We then asked respondents to consider a non-life-threatening situation regarding their mental wellbeing, and whether in that instance they could rely on members of their community to assist them. We see a similar response pattern to the previous question (Fig.25), with approximately 50 respondents who answered the question saying "Yes, members of my community would assist me",

but the majority responding either that they were *not sure*, or that members of their community *would not* assist them.

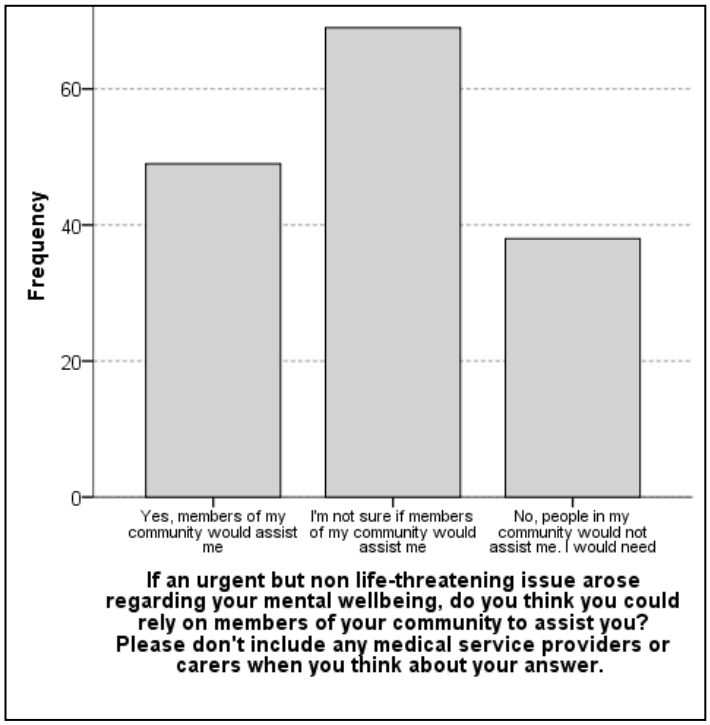

Figure 25: Number of respondents answering three options relating to extent of community support should a non-life-threatening mental health issue arise for them

These data enable us to begin to build up a picture that is *specific to the experiences of those with mental ill health in rural Scotland* – where "community" is not always sufficient as a support network. One of the reasons for this came through in the answer to a question which focused on the extent to which respondents felt they could be open about their mental ill health within their community. Although almost 50 respondents felt that they could be open, more than double this number of respondents stated that they could not be open within their own community (Fig. 26). If we then consider these findings in the light of those outlined above, around distance to mental health services (Fig.21), and the challenges of using public transport to receive the proper care to manage respondents' mental health (Figs.22 and 23), we see a composite picture starting to build, of potential isolation which can be made worse by feelings of geographical remoteness (Fig.20).

This isolation is further built upon by lack of access to places to meet with others to discuss mental ill health issues that respondents are facing. We asked whether respondents used a community or other centre to meet and socialise with other people with mental ill health. Although approximately 20 people said they did, more than six times as many said they did not (Fig.27). Based on the data we have, we are not able to say whether this response is due to personal choice or lack of rural facilities, but the outcome remains the same: the majority of those who answered this question are not socialising with other people with mental ill health in shared spaces in rural areas. This adds a further layer of lack of contact and potential support.

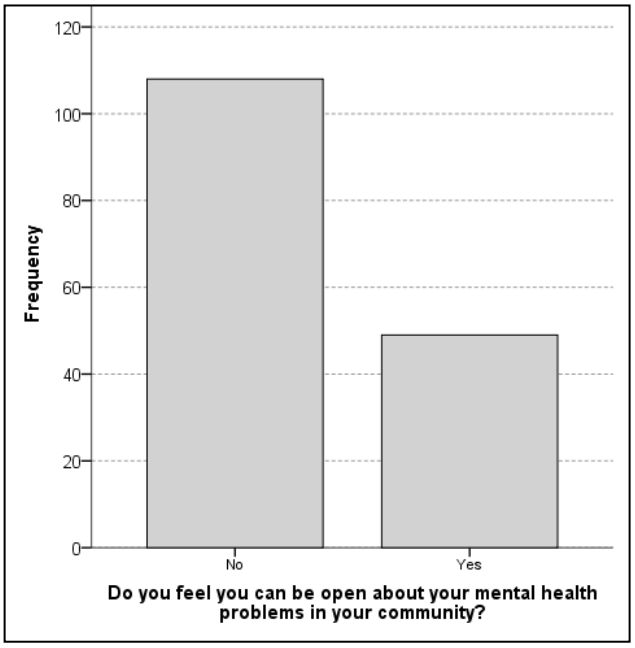

Figure 26: Number of respondents who can be open about their mental health problems in their community

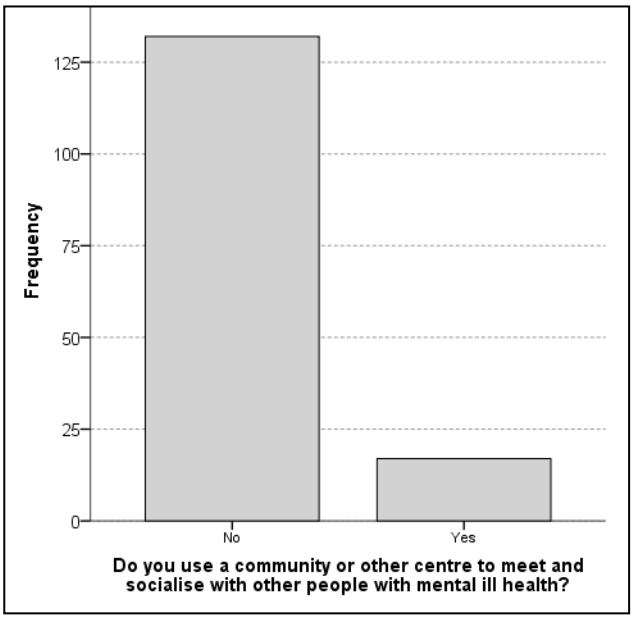

Figure 27: Extent to which respondents meet in a community or other centre to socialise with other people with mental ill health

4.3. Links between respondent characteristics and who they turn to for help

As with Figs.15-18 (above), the key purpose of these graphs (Fig.28-30) is to observe and compare *patterns* when looking at two graphs side-by-side. When comparing one graph with another, we are *not* looking at the difference in absolute numbers, but rather whether patterns are similar or different between the two graphs. As before, we have not presented individual commentaries, since

their aim is to generate thoughts and questions as to what might be behind these patterns or differences, and to identify possible directions for further inquiry or action.

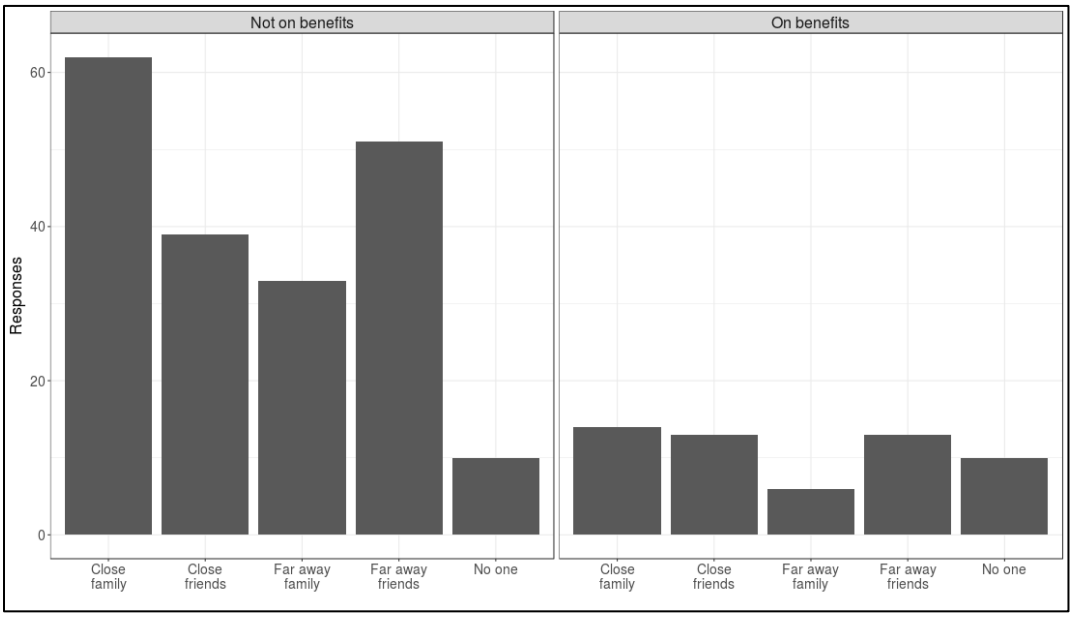

Figure 28: Whether or not respondents are on benefits and who they turn to for help

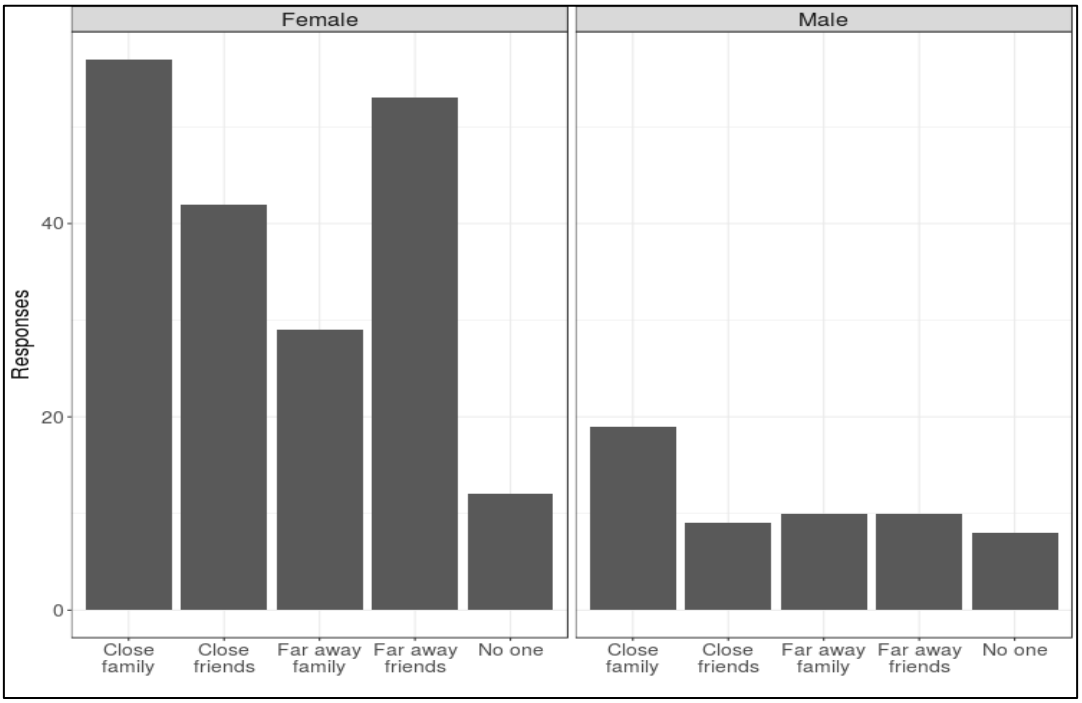

Figure 29: Gender and who respondents turn to for help

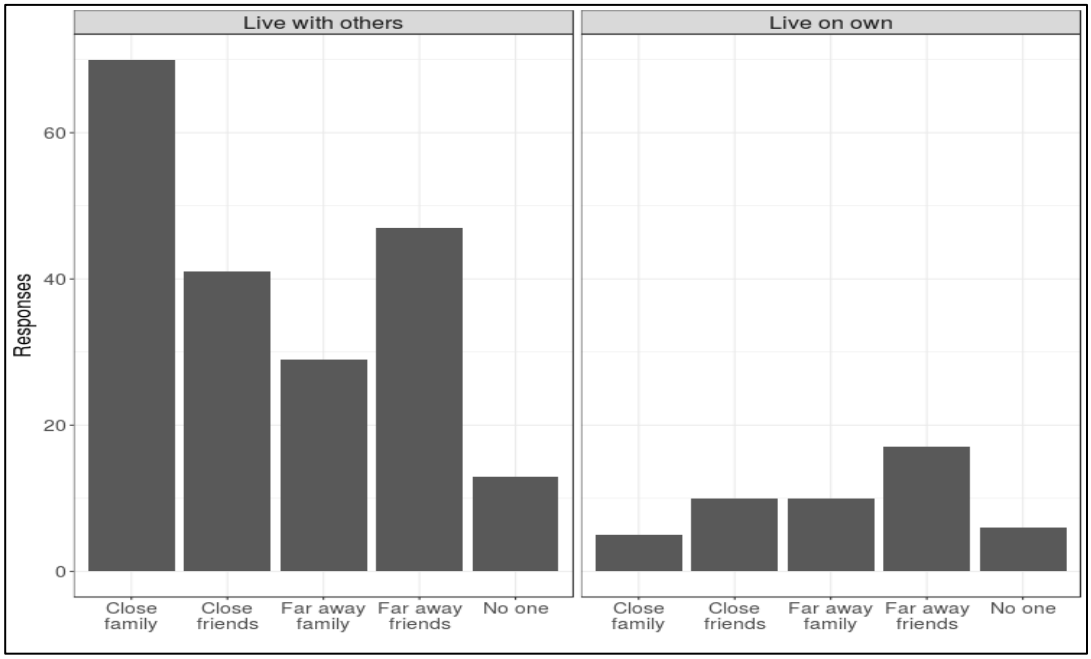

Figure 30: Whether respondents live on their own and who they turn to for help

4.4. Respondent's open-ended comments on their experience of their communities

The qualitative, open-ended responses to two questions have been analysed based on the occurrence of terms including *community, connections, neighbours, friends, family and local people*, as well as references to *(social) isolation* and sentences describing *people locally knowing about you and your business* etc. The two questions being analysed in this way are:

I. Advantages and Disadvantages about living in a remote area (two questions open to those who had answered that they considered themselves to live in a remote area) (Table 4);
II. Good or bad things about where you live (two questions open to all respondents) (Table 5).

There are two overall themes which emerge. Firstly, in relation to the **local community** of the respondent, familiarity and closeness appear to be a "double-edged sword" – providing comfort, security and homeliness to some, whilst being claustrophobic and judgemental for others. Secondly, those who found the community setting to be a disadvantage mentioned the **distance they experience from close friends and family** – meaning that their local community is insufficient in providing the closeness they need in comparison with what they miss from distant friends and relations.

These findings tie in with those from the closed questions (Figs.24-30), in that they show variability for respondents: *"community" is not a uniformly "good thing" for those experiencing mental ill health in rural Scotland*. We return to the significance of this, and what it might mean for the policy direction towards supporting people in their communities, at the end of this report.

Advantages or Disadvantages of living in a remote area – in relation to community	
Advantages (38/343 responses) 11 mention community, neighbours, friends, family, local people etc.	**Disadvantages (38/343 responses) 11 mention community, neighbours, friends, family, local people etc.**
Close communities	It's embarrassing that everyone knows you are too ill to work.
Stronger community links	Nosy neighbours, a strong disapproving and controlling religious network
Nice small community	Everybody knows who you are, knows your business, and makes assumptions based on things when they do not know the reality.
Close community with good locally run community hubs	Some people are a bit more nosy and judgemental.
Close friends and neighbours	People might know your business
People can help you, and do.	Very little opportunity to be sociable so quite isolating
Smaller, more personal communities.	Can be lack of privacy.
People don't bother you but are there for you.	Lack of like-minded people to be with.
A supportive community.	Community politics.
Fairly caring community.	Neighbours know "Everything" and stigma seems worse.
Community support.	Everyone knows you and your business

Table 4: Community-related advantages and disadvantages of living in a remote rural area

Good and bad things about where you live – in relation to community	
Good things (189/343 responses) 39 mention community, neighbours, friends, family, local people etc.	**Bad things (175/343 responses) 41 mention community, neighbours, friends, family, local people etc.**
Good friends.	A long way from my established friends and family
Local friends accept and include the person I care for.	Small communities not the best to talk about mental health issues
Good people.	No good friends in the area
Friends.	No friends nearby
Good community.	Isolation
Most folk know one another.	A long way from family
Good sense of community.	Isolated
Community spirit.	It is quite isolated
The banter of neighbours sometimes.	Bigoted neighbours
Small community.	Lack of transport to friends in villages
Local support from neighbours.	Distance from friends.
Good community feeling.	Village mentality - everyone knows everyone else's business.
I know all my neighbours	Parochial attitudes- racism -general ignorant attitudes.
Good community.	Smaller place means more stigma.
Familiar people, church.	The neighbours.
Good community spirit.	Isolation, lack of people, loneliness
Smaller communities where people are more helpful to each other.	Small town mentality - often there is no hiding place - people think they know you and can be

	very judgemental.
Small, friendly supportive village.	Narrow minded people.
Good community	Sometimes you feel everyone knows your business as it's a small town and tongues can wag!!
Good community	Small community.
Good neighbours	Social isolation.
Sense of community	Paranoia towards local gossip can stop me from leaving my house, no friends living nearby.
Well-meaning community.	Remote socially isolated.
Good community	Everyone knows everyone's business. It is hard to pretend you are doing fine but if you try to explain what is wrong, people do not understand and tend to avoid you.
People around me are willing to help when I have a problem. They are close but not too close.	Nosey neighbours.
Lots of friends	Not close to family.
Community	Goldfish bowl situation, everyone knows everything, can be judgemental.
Sense of community	Lack of knowledge and acceptance from traditional community.
It's familiar because you know most people around and near you.	Loneliness, isolation.
People around are willing to help. I don't feel enclosed	Socially isolating, far from friends.
Supportive community, feels safe, home	Everyone knows everything about everyone so you can't discuss anything with anyone.
Quite a supportive community.	Access to help, everyone knows everyone.
Local community group.	Lack of privacy in a small community.
Supportive community	Gossip.
Community, friends and family	Cannot guarantee confidentiality.
People	Social stigma and embarrassment about people finding out.
Community involvement	Close knit community means little privacy.
Close community	Everyone knows your problems and talks about them but won't actually talk to you and find out if you are ok.
Good neighbours	Smaller place, more stigma, feel like everyone knows your business.
	Growing up in the same community and not moving and settling elsewhere, means everyone has a vast amount of information about me… But here it can be difficult to look forward when people's opinions are based on things you used to do and not the person you have become.
	I could go weeks without seeing anyone if I wanted to as no neighbours directly next door nearest is a quarter mile.

Table 5: Community-related good and bad things about where you live

5. Respondents key messages for service providers and policy makers

5.1. Introduction

To conclude the questionnaire, respondents were asked:

I. **If you could change one thing about mental health services in rural Scotland, what would that be and why?**

II. **What key message do you want to tell policy makers to help you manage your mental ill health in a rural setting?**

The purpose of these two questions was to give respondents the opportunity to reflect and communicate their thoughts on what needed to change for them, given their experiences of living with mental ill health in a rural setting in Scotland. There was no structure to the questions, and no prompts were given.

This sub-section is structured as follows:

1. For each of the two questions, the overall key messages are given.
2. Responses for each question are then presented according to the following categorisations:
    a. Respondents' gender;
    b. Respondents' age;
    c. Respondents' self-reported mental health issue - suicidal thoughts and feelings, depression, or self-harming.
3. *Within* each of these categorisations (age, gender, self-reported mental health issue), the main themes are identified, using a recognised thematic analysis approach. The key points are summarised at the beginning of each section, and then the evidence is presented in more detail.

5.2. "If you could change one thing about mental health services in rural Scotland, what would that be and why?"

5.2.1. Summary of all key messages

Box 1 summarises the key messages that were put forward by respondents across all categories:

"If you could change one thing about mental health services in rural Scotland, what would it be and why?"

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

Box 1: Summary of respondents' key messages relating to mental health services in rural Scotland

5.2.2. Respondent's *gender* and their suggestions for rural mental health services

Suggestions as to what needs to change could be differentiated according to whether the respondent was male or female (Box 2). In addition, specific ideas were brought forward by only males or females.

- **Males focused on:**
  - the need for publicity and raising awareness around mental health;
  - increasing the speed of access to support, including through online media. *Only males mentioned online support.*
- **Females focused on:**
  - The need for more availability and accessibility, particularly through local outreach approaches;
  - Non-drugs-based approaches, particularly the importance of talk-based therapies, alternative therapies and increasing the range of treatment options. *Only females talked about these aspects.*

Box 2: Male and female respondent's suggestions regarding rural mental health services

It is important to note that these male-*only* and female-*only* responses came via a totally open-ended question. If we were then to *prompt* for whether these specific issues (internet-based support and talking-based therapies) should receive greater investment, we may well see different gender-related patterns. Nonetheless, the fact that these two elements were *voluntarily suggested* only by men and women respectively is significant, potentially providing useful pointers to gender-related preferences in mental health service provision.

The more detailed gender-related responses are listed below (Boxes 3 and 4).

Male respondent's proposals for changes in rural mental health service provision:

1. *Raise awareness:*
   a. I would work to raise awareness around mental health and make it as normal disease like diabetes or cancer.
   b. It is absolutely essential to publicise facilities and illnesses more.
   c. Increase education at primary school about them.
   d. Education instead of believing pop culture and the media.

2. *Increase speed of access, including online:*
   a. More crisis help to help sooner.
   b. Waiting times:
      i. Quicker referral to Mental Health Team as took 6 months to speak with MHT.
      ii. Getting an appointment. It can take up to 9 months at the moment.
      iii. More services less waiting times.
   c. Online *(only males talked about this)*:
      i. Mental health services accessible online.
      ii. Being able to access CPN by Skype or equivalent.

Box 3: Male respondent's proposals for changes to rural mental health services

Female respondent's proposals for changes in rural mental health service provision:

1. *More availability/accessibility :*
   - **a. More outreach:**
     - i. More outreach services and a better understanding.
     - ii. Improved contact with services from town. More visits/ support/ So basically more outreach facility to increase contact with services.
     - iii. Given the stress of travel, more home visits by CPNs who would be better able to assess patients at home and see their difficulties.
   - **b. More availability locally:**
     - i. Easier access in a neutral, discreet place.
     - ii. Have services in community hubs rather the towns and cities.
     - iii. There would be something in each local GPs health centre or cottage hospital for people to access.
     - iv. Better accessibility at a grassroots level in the community.
     - v. I would have more mental health services … create more services and let it constantly be advertised to make people aware of mental health and to become more accepting and for others not hide away because of their ill mental health.
     - vi. I don't know of any crisis centres near where I live even though suicide rates are high among young men.
     - vii. They should be more accessible to young people and people with low incomes as they have the greatest barriers when trying to access services.
     - viii. More resources for children and women with mental health problems.

2. *Not drugs-based (only females mentioned this):*
   - **a. Importance of talking:**
     - i. More work that reduces the stigma around talking, so that people can start to improve their mental health at home and in their communities.
     - ii. There should ALWAYS be a good support network when someone is discharged from hospital. They should NEVER feel that they have been left alone to get on with things and they should be encouraged to go along to some groups etc. to see if they like it.
     - iii. The option of counsellors travelling to you.
     - iv. Better access to talking therapies.
     - v. More drop-in services with trained staff in Youth Clubs and more open discussions and group meeting points for people affected with mental health issues. There needs to be more support given to communities in tackling issues and there needs to be more awareness and A LOT more support offered to young people in schools.
   - **b. Recognise alternative approaches:**
     - i. Easier to access therapies that are not drug-based; alternatives to drug therapy.
     - ii. More easily accessible non-GP help + wider acceptance of alternative therapies by GP community.
     - iii. GPs more willing to run vitamin deficiency tests or look for an underlying condition instead of handing out anti-depressants.
     - iv. A safe, welcoming, attractive respite centre that acted as a halfway house between being at home and in hospital that offered range of therapeutic treatments such as yoga, mindfulness, creative activities, privacy, quiet and attractive surroundings.
   - **c. Need range of options available:**
     - i. Have a broader range of therapies for complex needs.
     - ii. Making psychological therapies more widely available.
     - iii. Better and more support for people with addictions, we need more therapists.

Box 4: Female respondent's proposals for changes to rural mental health services

5.2.3. Respondent's *age* and their suggestions for rural mental health services

The two age brackets where themes were observable were the under 24s (the youngest respondent being 16), and those aged 45-54 (Box 5); the more detailed responses are shown in Boxes 6 and 7.

- **Those aged 16-24 focused on:**
  - Increasing the geographic spread to bring services closer;
  - Home visits;
  - Recognising specific support needs.
- **Respondents aged 45-54 focused on:**
  - The need for tailored care.

Box 5: Respondent's themes regarding rural mental health services, according to two age brackets

Respondents aged 16-24: proposals for changes in rural mental health service provision

1. *Provision and access*
   - **a. Increase geographic spread to bring services closer:**
     - i. Greater coverage - more qualified folk on the ground.
     - ii. I'd have more services available throughout the region instead of in one location.
     - iii. It's really difficult in a rural area, but I don't know of any crisis centres near where I live even though suicide rates are high among young men. I'm not sure how effective they are at reducing suicide rates, but I'd be interested to know.
     - iv. The most important thing is that we desperately need more mental health specialists/professionals and psychiatrists in Scotland, especially in the Orkney Islands because there are increasingly more young people with worsening mental health conditions and people committing suicide with nothing truly helpful being done about it.
   - **b. Home visits:**
     - i. More home visits to monitor.
     - ii. The option of counsellors travelling to you.
   - **c. Recognise specific support needs:**
     - i. Have a broader range of therapies for complex needs.
     - ii. Better access to psychological support.
     - iii. They should be more accessible to young people and people with low incomes as they have the greatest barriers when trying to access services.
     - iv. More resources for children with mental health problems.

2. *Raise awareness:*
   - **a. At school:**
     - a. Increase education at primary school about them.
     - b. Education instead of believing pop culture and the media.
   - **b. More widely:**
     - a. Make it normal and understood.
     - b. More publicity is essential... It is absolutely essential to publicise facilities and illnesses more
     - c. Having a resource bus that could visit all the villages where people could go to get more information that is accurate, make a self-referral for help, find out about local support groups, speak to trained medical staff.

Box 6: Proposals for changes in rural mental health service provision from those aged 16-24

Respondents aged 45-54: proposals for changes in rural mental health service provision

1. *Tailored care:*
   a. Have a key worker (CPN, social worker) who co-ordinated a tailored care plan between the requisite agencies.
   b. Have a guardian who can help discuss things with doctor.
   c. Better GP understanding of mental health problems and better referral to specialist help.
   d. Better access to talking therapies.
   e. More inclusive service for women with mental health issues.
   f. Better and more support for people with addictions, we need more therapists.

Box 7: Proposals for changes in rural mental health service provision from those aged 45-54

5.2.4. Respondent's *self-reported mental health issues* and their suggestions for rural mental health services

We then analysed the same suggested changes to mental health services in rural Scotland according to three self-reported mental health issues: *suicidal thoughts and feelings, depression and self-harm*. The purpose of this part of the analysis was to identify whether there were any service suggestions which appear to be relevant to particular mental health issues. As we saw in the discussion relating to challenges of using public transport (Fig.23), we wanted to know whether people's self-reported issues had a link with the types of service proposals they then made. Key themes emerged from this analysis (summarised in Box 8), which are 'unpacked' further below (Boxes 9 to 11).

- **Suicidal thoughts and feelings:**
  - Crisis and pre-crisis help, coupled with shorter waiting times
  - Location of support (including specific islands-related issues)
- **Depression:**
  - More local, accessible services (includes addressing challenges of travelling)
  - Tailored care
  - Mainstreaming
- **Self-harm:**
  - Focus on children and young people
  - Shorter waiting times
  - Local services

Box 8: Suggestions for rural mental health services, linked with respondents' self-reported mental health issues

Respondents who self-reported suicidal thoughts and feelings

The main emphasis for these respondents was on the need for much-improved *local* support that was available at times of crisis and *pre*-crisis, and could include outreach services in "low-level", non-clinical settings (such as village halls, outreach buses and other mobile services) (Box 9). This would not only improve access to support but would also raise awareness of mental health issues and of available help. Services on the islands were felt to be particularly needed, given anecdotal reports of a rise in suicides; again, this links back to respondents' sense of remoteness and challenges of using public transport cited earlier in this report.

Respondents self-reporting suicidal thoughts and feelings: their proposals for changes in rural mental health service provision

1. **Crisis and pre-crisis support including shorter waiting times:**
    a. More crisis help to help sooner.
    b. For there to be a shorter waiting list to access support; getting an appointment; it can take up to 9 months at the moment.
    c. More accessible, shorter waiting times for appointments.
    d. It's really difficult in a rural area, but I don't know of any crisis centres near where I live even though suicide rates are high among young men. I'm not sure how effective they are at reducing suicide rates, but I'd be interested to know.
2. **Location of support (including specific islands issues):**
    a. *Travelling services, being creative:*
        i. Having a resource bus that could visit all the villages where people could go to get more information that is accurate, make a self-referral for help, find out about local support groups, speak to trained medical staff.
        ii. Services being creative about how to get out into rural communities,
        iii. Improved contact with services from town. More visits/ support/ So basically more outreach facility to increase contact with services.
        iv. The option of counsellors travelling to you.
        v. Services based in rural areas e.g. travelling services, use of local village halls, school etc.
        vi. More support groups in local areas. More out-reach support,
    b. *Islands:*
        i. Accessibility directly on the island and not just mainland.
        ii. I would have more mental health services, I cannot speak for other islands but the Isle of XX has next to nothing. If I were in charge I would focus on the most rural areas like XX and create more services and let it constantly be advertised to make people aware of mental health and to become more accepting and for others not hide away because of their ill mental health.
        iii. The most important thing is that we desperately need more mental health specialists/professionals and psychiatrists in Scotland, especially in the XX Islands because there are increasingly more young people with worsening mental health conditions and people committing suicide with nothing truly helpful being done about it.
        iv. To have more facilities and resources and professionals full time on the island.

Box 9: Proposals for changes in rural mental health service provision from those self-reporting suicidal thoughts and feelings

Respondents who self-reported depression

The key issues highlighted by these respondents (Box 10) included the need for more local services, based in the community, which links closely with the findings from the analysis of quantitative data that showed the stress of travelling in order to reach mental health appointments. These are seen as a mix of more formalised services (through GPs and nurses, for example) with those in informal settings in village halls and local support groups. The need for tailored services was emphasised, particularly those addressing pre-crisis situations, coupled with a greater emphasis on GPs and other 'mainstream' services recognising mental health conditions, plus knowing when to refer to specialists and when to take a more holistic approach.

Respondents self-reporting depression: their proposals for changes in rural mental health service provision

1. **More local, accessible services (includes challenges of travelling):**

a. *Stress of travel:*
   i. Closer to resources. Nearest CHAMS is over 214 round trip, nightmare on public transport.
   ii. Given the stress, cost and time taken to attend Clinics, hospitals miles away, I would have more home visits by CPNs who would be better able to assess patients at home and see their difficulties.

b. *Need for outreach services:*
   i. More outreach services and a better understanding.
   ii. More visits/ support/ so basically more outreach facility to increase contact with services.

c. *Services based in the community:*
   i. Greater coverage - more qualified folk on the ground.
   ii. There would be something in each local GPs health centre or cottage hospital for people to access.
   iii. Better accessibility at a grassroots level in the community.
   iv. More nurses in the community.
   v. More local support groups.
   vi. I'd have more services available throughout the region instead of in one location (Dumfries).
   vii. I would have more mental health services, I cannot speak for other islands but the Isle of Barra has next to nothing.

2. **Tailored care:**

a. *Pre-crisis:*
   i. More capacity to see patients before crisis point.
   ii. More than crisis related; more facilities before crisis stage.
   iii. Service is only for high risk situations. No specialist services either.

b. A 1to 1 patient care, tailored to the individual needs.

c. They should be more accessible to young people and people with low incomes as they have the greatest barriers when trying to access services.

d. More resources for children with mental health problems.

3. **Mainstream it:**

a. *NHS/GPs:*
   i. Make it fully part of the NHS not a bolt on hidden part of the NHS.
   ii. Better GP understanding of mental health problems and better referral to specialist help.
   iii. GPs more willing to run vitamin deficiency tests or look for an underlying condition instead of handing out anti-depressants.

b. More work that reduces the stigma around talking, so that people can start to improve their mental health at home and in their communities.

Box 10: Proposals for changes in rural mental health service provision from those self-reporting depression

Respondents who self-reported self-harming

The priority issue appeared to be the need to focus on children and young people, and particularly those on lower incomes who face barriers of being able to access services (e.g. through not being able to pay for transport), ensuring that waiting times are shortened and that services are available locally. These findings link with the quantitative findings around the challenges of rural transport.

Respondents self-reporting self-harming: their proposals for changes in rural mental health service provision

1. **Children and young people:**

a. They should be more accessible to young people and people with low incomes as they have the greatest barriers when trying to access services.
b. The most important thing is that we desperately need more mental health specialists/professionals and psychiatrists … especially in the XX Islands because there are increasingly more young people with worsening mental health conditions and people committing suicide with nothing truly helpful being done about it.
c. More resources for children with mental health problems.

2. **Shorter waiting times:**

a. More services less waiting times.
b. For there to be a shorter waiting list to access support.
c. Getting an appointment; it can take up to 9 months at the moment.

4. **Local services:**

a. Greater coverage - more qualified folk on the ground.
b. Better accessibility at a grassroots level in the community.
c. The option of counsellors travelling to you.
d. I'd like my therapist to be able to come to the island sometimes.
e. Having a resource bus that could visit all the villages where people could go to get more information that is accurate, make a self-referral for help, find out about local support groups, speak to trained medical staff.
f. More nurses in the community.

Box 11: Proposals for changes in rural mental health service provision from those self-reporting self-harming

5.3. "What key message do you want to tell policy makers to help you manage your mental ill health in a rural setting?"

5.3.1. Summary of all key messages

Box 12 summarises the key messages that were put forward by respondents across all categories (i.e. gender, age and self-reported mental health issue):

"What key message do you want to tell policy makers to help you manage your mental ill health in a rural setting?"

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

Box 12: Summary of respondents' key messages for policy makers

This section follows the same structure as with Section 5.2. (above). That is, we report respondents' messages for policy makers according to their gender, age and their self-reported mental health issues (suicidal thoughts and feelings, depression, or self-harming). Where is it possible to identify patterns within the responses, these are presented below.

5.3.2. Respondent's *gender* and their messages to policy makers

Male and female respondents' key message for policy makers focused on different issues (Box 13), with specific recommendations being brought forward either by males only or females only.

- **Males focused on:**
    - Treating mental health the same as physical health. *Only males mentioned this.*
- **Females focused on:**
    - The impact of isolation on mental wellbeing;
    - The importance of connection and talking. *Only females highlighted these aspects.*

Box 13: Male and female respondent's key messages for policy makers

As with the previous question on suggested changes in mental health services in rural areas (Box 2), it is important to note that these male-*only* and female-*only* responses came via a totally open-ended question. If we were then to *prompt* for these specific issues (parity between mental and physical health, and the importance of connection and talking), we may well see different gender-related patterns. Nonetheless, the fact that these two elements were *voluntarily* suggested only by men and women respectively is significant, and may suggest gender-related preferences.

The more detailed gender-related responses are shown below (Boxes 14 and 15).

Male respondent's key messages for policy makers:

1. **Treat mental health the same as physical health:** *only males gave this response*

a. Mental health is very poorly resourced and co-ordinated. Why is it not more like mainstream medicine? It SHOULD be.
b. Everybody has mental health, just like everybody has a heart in their chest. You wouldn't ignore your heart if it started to hurt.
c. Please treat people with mental health problems the same as people with other physical health problems.
d. Mental illness seen as equal as physical illness.

Box 14: Male respondent's messages for policy makers in relation to mental health in rural Scotland

Female respondent's key messages for policy makers:

1. **Impact of isolation on mental wellbeing:**

a. Isolation aggravates mental illness.
b. Isolation is a big problem
c. Being alone can be part of the problem also more understanding of SAD especially north of Inverness very important.
d. Realise that isolation is a huge factor in poor mental health - transport difficulties can be solved.
e. Isolation and lack of services need to be addressed
f. Transport:
    i. Support community transport to help get people there
    ii. Good communication and good public transport really help

2. **The importance of connection and talking:** *only females mentioned this*

a. Community hubs and support groups:
    i. Develop strong community hubs with free drop-ins and bus waiting areas !! and public transport systems for them to be accessed.
    ii. Improve access to help - whether that is access as in opening village hall for tea and chat or bus service to health services.
    iii. Support varied community initiatives that bring people together as a community.
    iv. Knowing that you're not alone and many others suffer too. Make it easier for people to talk to each other i.e. support groups.
b. There should ALWAYS be a rehabilitation team there to support patients who have just been discharged from hospital and continued support from a CPN. Not just ""thrown"" out if the door with medication and left to ""get on with it"". Support is key to keeping well.
c. Find a way to have a meaningful dialogue with people with mental health issues. More often than not, they will tell you the best way to help them manage their condition. Listen. Listen. Listen.
d. There is too much relying on yourself having to go online to deal with self-help schemes and to speak to people on the phone.
e. Talking therapies:
    - There should be 'listening' therapists/counsellors much more widely available.
    - Better provision of talking therapies.

Box 15: Female respondent's messages for policy makers in relation to mental health in rural Scotland

In addition, female respondents recognised that the need for talking about personal mental health issues is complex, since it raises issues around who to talk to in close-knit communities, coupled with the fact that some people want to talk but cannot, as shown by the following two quotes.

> "Having difficulty expressing my issues, being able to do this in a way which is not face to face with someone you are likely to bump into in town, would give a freedom to express and explain exact feelings and fears. Hopefully meaning people could get to the honest route of the problem."
> "Stop ignoring us! There is no point telling farm dwellers to talk about their mental health issues....they won't and actually can't."

5.3.3. Respondent's *age* and their messages to policy makers

This analysis of responses led to perhaps the most stark patterns in terms of linkages between respondents' characteristics and types of messages given (Box 16). Those aged 16-24 were extremely clear in stating that mental ill health leads to death – they did not "sugar-coat" their message at all – and therefore highlighted the need to prioritise, and listen to, those experiencing mental ill health. Respondents aged 25-34 emphasised the need not to over-medicalise, with an associated focus on improved training and development to enhance support, while those aged 35-44 focused on isolation issues. Boxes 17-19 present these findings in more detail.

- **Respondents aged 16-24 focused on:**
  - Mental ill health is a serious issue.
  - Mental ill health leads to death.
  - Mental health needs to be prioritised.
  - Service users need to be listened to.
- **Respondents aged 25-34 focused on:**
  - Don't over-medicalise mental ill health.
  - Instead, increase understanding, training and development.
- **Respondents aged 35-44 focused on:**
  - Isolation and remoteness.

Box 16: Respondent's messages for policy makers, according to three age brackets

Key messages for policy makers from respondents aged 16-24:

1. **Mental ill health is a serious issue – mental health leads to death**

a. Mental health and death:

i. Get a grip people are dying from mental ill health.
ii. Mental health services need to be protected and enhanced not cut - they save lives.
iii. Suicide is high due to little help or late help.
iv. My brother has Schizophrenia, he get no support in the local community. CPN/ services need to be proactive & encourage. If he didn't have family he would be dead.
v. The current waiting time is dangerous, anyone who is having to wait a significant amount of time to be seen will be at a greater risk for self-harm or suicide.
vi. We truly desperately need more psychiatrists/mental health specialists in the

Orkney Islands, there are too many people on this island (including myself) with no beneficial / proper psychiatric help available to treat and help specific mental health conditions, as well as preventing the massive increase in suicides.

b. Prioritise mental health:

i. Invest in mental health support or the problem will get worse.
ii. You obviously can't change people's minds, but try harder to show that mental health is something to be taken seriously.
iii. Mental illness isn't something to be swept under the carpet - it MUST be addressed.

c. Listen to service users:

i. Listen to those who are in crisis or have faced a challenge, instead of listening to the professionals who read the DSM (Diagnostic and Statistical Manual of Mental Disorders).

Box 17: Key messages for policy makers in relation to mental health in rural Scotland, from respondents aged 16-24

Key messages for policy makers from respondents aged 25-34:

1. Don't over-medicalise mental health – increase understanding:

a. Mental health is just as much a function of loneliness and social isolation as it is an organic condition. Don't over medicalise MH but instead build community capacity.

b. Training and development needed:

i. Invest more in training and development of staff, GPs and nurses - Large sectors of our communities even healthcare providers are not very much aware of the mental health issues.
ii. Public services should be fully aware of the mental health issues of people and how to help and support.
iii. Not just medication.
iv. Low level support for people like myself living with mild mental illness as we just get medication thrown at us with no follow up at all. No referral to any support service. Just a box of pills.
v. Think about the person not the condition.
vi. Need more and flexible range of services to meet individuals needs.
vii. It is an invisible illness and every person is different in their journey.

Box 18: Key messages for policy makers in relation to mental health in rural Scotland, from respondents aged 25-34

Key messages for policy makers from respondents aged 35-44:

1. Isolation:

a. Isolation and lack of services need to be addressed.
b. Poor broadband makes one isolated.
c. Don't make me feel it is my fault that I live in the middle of nowhere and can't drive and am stuck. Provide reliable transport offer it or make it easily available. Don't tell me that as I have a nice view I must be feeling better!!!!
d. There is too much relying on yourself having to go online to deal with self-help schemes and to speak to people on the phone.

Box 19: Key messages for policy makers in relation to mental health in rural Scotland, from respondents aged 35-44

5.3.4. Respondent's *self-reported mental health issues* and their messages to policy makers

In this section, we analysed the same messages to policy makers, according to respondents' three self-reported mental health issues: *suicidal thoughts and feelings, depression and self-harm*. The purpose of this part of the analysis was to identify whether there were any key policy messages which appear to be relevant to particular mental health issues. Key themes emerged from this analysis (summarised in Box 20), which are 'unpacked' further below (Boxes 21 to 23).

- **Suicidal thoughts and feelings:**
  - Mortality – mental ill health leads to death, and services are a lifeline
  - Remoteness/geographical location – impact on services
  - Accessible support crucial in rural areas
  - Listen to service users
- **Depression:**
  - Social isolation is a key factor in mental ill health, for the employed as well as the unemployed
  - Improve low-level contact in communities through multiple approaches
- **Self-harm:**
  - Local services – access and awareness
  - Reduce waiting times – reduces suicides

Box 20: Key messages for policy makers related to rural mental health, linked with respondents' self-reported mental health issues

Respondents who self-reported suicidal thoughts and feelings

The key messages for policy makers, when analysed in relation to those who self-reported suicidal thoughts and feelings (Box 21), show a focus on the impact of mental ill health on mortality, i.e. its seriousness and therefore the lifeline, literally, that mental health services provide for users. Respondents also raise the issue of equity in terms of being able to access such services irrespective of where they happen to live, be that "in the middle of nowhere" or on an island. Overcoming isolation is viewed as key, with the need to create multiple, complementary approaches to addressing this, i.e. thinking beyond traditional bricks-and-mortar delivery methods in clinical environments. The final point in Box 21 reinforces the need for sensitive and empathetic approaches, because of the complexity of reaching people who *want* to connect, but at the same time *cannot,* for multiple personal reasons.

Respondents self-reporting suicidal thoughts and feelings: their key messages for policy makers

1. **Mortality:**
   a. Mental health services need to be protected and enhanced not cut - they save lives. And not just front line services, but projects and services that help people stay mentally well and healthy like arts projects and social farming projects etc.
   b. Take mental health seriously...it can be life threatening.
   c. Get a grip people are dying from mental ill health,

2. **Remoteness/geographical location:**
    a. Don't make me feel it is my fault that I live in the middle of nowhere and can't drive and am stuck. Provide reliable transport offer it or make it easily available. Don't tell me that as I have a nice view I must be feeling better!!!!
    b. We truly desperately need more psychiatrists/mental health specialists in the XXX Islands, there are too many people on this island (including myself) with no beneficial / proper psychiatric help available to treat and help specific mental health conditions, as well as preventing the massive increase in suicides.

3. **Accessible support:**
    a. Create and support more rural and accessible mental health services and treatments (e.g. portable mental health clinics and support groups).
    b. We need more crisis houses so people can get 24/7 support outwith the hospital environment.
    c. Knowing that you're not alone and many others suffer too. Make it easier for people to talk to each other i.e. support groups.
    d. Realise that isolation is a huge factor in poor mental health - transport difficulties can be solved.

4. **Listen to service users:**
    a. Stop ignoring us! There is no point telling farm dwellers to talk about their mental health issues....they won't and actually can't.
    b. Sometimes … if you haven't been through it you may not fully understand properly.

Box 21: Key messages in relation to rural mental health in Scotland, from those self-reporting suicidal thoughts and feelings

Respondents who self-reported depression

The first theme which emerged strongly (Box 22) was that of isolation, with every person experiencing this in their own way due to personal circumstances, including not being able to drive or use public transport, as well as structural deficits including poor broadband. Respondents highlighted the support needs of those *in* work – an important point to remember, given the policy direction-of-travel towards supporting those with mental ill health to enter into meaningful paid employment (a point we return to in the conclusions of the report). A second significant theme is that of improving access to "low-level" support, in non-clinical, community settings. These messages about connecting are coming from those experiencing mental ill health, and it is therefore important to understand the urgency and importance of these priorities from the respondents' point of view.

Respondents self-reporting depression: their key messages for policy makers

1. <u>Social isolation:</u>
    a. It is an invisible illness and every person is different in their journey.
    b. Isolation aggravates mental illness.
    c. Mental health is just as much a function of loneliness and social isolation.
    d. Not everyone can drive or has the ability to use bus services which are not that frequent in rural areas.
    e. Poor broadband makes one isolated.
    f. Those in employment:

i. Need for community support that enables people who work during the day to access them.
ii. Better training for managers to help employees.

2. **Low-level contact in communities:**
   a. Improve access to help - whether that is access as in opening village hall for tea and chat or bus service to health services.
   b. Support varied community initiatives that bring people together as a community.
   c. Develop strong community hubs with free drop-ins and bus waiting areas!! and public transport systems for them to be accessed.
   d. Sometimes all you need is a friend, someone who listens. Don't add pressure and don't push someone to get better - take it in their steps. We need to rethink mental wellbeing , stop stigmatising.
   e. Knowing that you're not alone and many others suffer too. Make it easier for people to talk to each other i.e. support groups.
   f. More outgoing support for families and we still need to crack discrimination within communities.

Box 22: Key messages in relation to rural mental health in Scotland, from those self-reporting depression

Respondents who self-reported self-harming

The key message to come through from those respondents who are reporting self-harming is that they require local services with reduced waiting times. These services do not need to be within clinical environments – indeed, there is recognition that services and treatments need to be more accessible and could be available through community services, local groups and home visits, as well as through crisis houses. If these more flexible, local services are not created and supported, then respondents' concerns are that help will arrive too late.

Respondents self-reporting self-harming: their key messages for policy makers

1. **Local services:**
   a. We need more crisis houses so people can get 24/7 support outwith the hospital environment.
   b. Stress of travelling to appointments (especially in winter).
   c. Fund local groups who help.
   d. Home visits.
   e. Create and support more rural and accessible mental health services and treatments (e.g. portable mental health clinics and support groups).
   f. Make it more easily accessed and people more aware of community services.

2. **Waiting times:**
   a. Suicide is high due to little help or late help.
   b. Shorter waiting times for assessment.

Box 23: Key messages in relation to rural mental health in Scotland, from those self-reporting self-harming

Key points and their implications

Key points

Living with mental ill health: The evidence from the survey of 343 respondents has given insights into how people with mental ill health, and with a range of specific self-reported mental health issues, are *experiencing life in rural Scotland*. Uniquely, this survey has given an opportunity for *people's own voices* to be articulated and presented, through multiple choice and open-ended questions. Although insights have been gained into how respondents perceive mental health services, including how they can be improved, the real merit of the data is in 'unpacking' the nuances of experiences and what those *mean* for people living with mental ill health in rural Scotland.

Self-reported mental health issues: During the summer months of the survey, 67% of those responding self-reported depression, with 22% of respondents self-reporting suicidal thoughts and feelings – with patterns in self-reported issues similar across rural Scotland. The survey gave us insights into their thoughts, concerns and proposals for change.

Employment, gender and age: The majority of survey respondents are in employment; we therefore have data from those in employment who are also experiencing self-reported mental health issues, giving valuable new insights. Plus we now have greater understanding of how, for the respondent sample, mental health issues are experienced differently across gender and age, plus how gender and age create particular perspectives on service and policy issues.

Geographical location and isolation: The findings show an important distinction between respondents' *actual* geographical remoteness (based on postcodes) and their *perceived* or *experienced* geographical remoteness, that is, how geographically remote people actually *felt*. This was also linked with distance to mental health facilities, and ease or otherwise of accessing public transport – highlighting the "layers" of remoteness and isolation that can build up, particularly for individuals with certain mental health issues such as self-harming and suicidal thoughts and feelings.

Communities: The survey data has generated key insights around the theme of communities, particularly the extent to which respondents feel they are supported and can talk about their mental health problems within their own communities. The evidence shows how community can be a 'double-edged sword', by being close and strong for some, while being judgemental and parochial for others, directly affecting who people turn to for help.

Key question 1: If you could change one thing about mental health services in rural Scotland, what would it be and why? Six main points came through from the open-ended responses:

- There is a need and desire to create ways for people to connect with one another *before* their personal crises occur;
- These connections need to be "low-level", in non-clinical and informal settings, through trusted people and networks;
- Services need to be close to the place of need, designed to include mobile services and outreach, particularly on the islands; this "outreach" approach recognises the significant stress of travelling *to* appointments for those with mental ill health;
- Mental health care must be mainstreamed within the NHS and not a "bolt-on";

- There must be parity between mental and physical health care;
- There must be an increased focus on the needs of children and young people, reducing waiting times, particularly in relation to self-harming.

Key question 2: What key message do you want to tell policy makers to help you manage your mental ill health in a rural setting? Five main points emerged from the open-ended responses:

- Mental ill health is an invisible illness – made more invisible by being rural and remote;
- Users of mental health services must be listened to and respected;
- Mental ill health does lead to death – it is a serious issue;
- There must be shorter waiting times to see specialists;
- There must be support for "low-level" contact outwith hospital environments, close to communities.

Implications

There are four main implications to be considered from these findings; these are now briefly outlined.

1. **Legitimacy:** this research has presented the voices of those experiencing mental ill health in rural Scotland. By so doing, we aim to legitimise the voices of those with mental health issues. Those responding stated that, at the time of the survey, they were experiencing a range of mental health issues; this makes their views no less valid, in fact it *enhances* their validity, given the focus is on their experiences and proposals for what needs to change to improve their mental wellbeing in a rural setting.

2. **Communities:** the research has uncovered important nuances and complexities around the extent to which respondents feel that the communities in which they live are, and can be, supportive of them. This is extremely important in and of itself, in terms of overcoming social isolation, and addressing issues of stigma and prejudice. It is also important due to the direction-of-travel, in policy and practice, towards community-based health and social care. The voices of those experiencing mental ill health in rural Scotland point to limitations in the extent of community support, and in terms of how open they feel they can be about their mental ill health. This raises important issues of capacity for inclusion within some rural communities, as well as the opportunities for learning from those communities who are inclusive of those who have mental health issues. There is work to be done in understanding how to engender and support well connected communities so that they can provide the appropriate "low-level, non-clinical, local, trusted" approaches that are called for by respondents, and how the work of the *National Rural Mental Health Forum* can support this inclusive shift at national and regional levels (see **Appendix 3** for list of Members and for contact point for more information).

3. **Policy:** as mentioned in the Foreword and Introduction, the Government's new ten-year *Mental Health Strategy* was published in March 2017. There is recognition of isolation and its challenges being "keenly felt by many in our rural communities" (p.20), as well as the difficulties in rural areas of accessing services and support for mental health. There is reference to the **National Rural Mental Health Forum**: "established to help people in rural

areas maintain good mental health and wellbeing. This Forum will help develop connections between communities across rural Scotland, so that isolated people can receive support when and where they need it". A specific Action is described in the Strategy: *Support the further development of the National Rural Mental Health Forum to reflect the unique challenges presented by rural isolation* (Action 12). There is scope, therefore, to continue to feed evidence from the rural survey into the Forum and the ten-year Strategy, *and* to build on this initial evidence-base through further exploration of the themes which have been raised in this report.

Given the specific evidence generated through this survey, it will also be important to feed a rural perspective into the: (i) *Suicide and Self-Harm Strategy or Action Plan*, due to be consulting in 2017 with a possible launch in 2018; and (ii) the *National Strategy to tackle Social Isolation*, currently under discussion (April 2017).

The new survey evidence is of relevance to policies around community empowerment and employment - touching on the implementation of the *Community Empowerment (Scotland) Act 2015* (for example through Community Planning Partnerships and their Local Outcome Improvement Plans), and the 2016/17 *Enterprise and Skills Review*. Further, given the specific issues highlighted in the islands, the existence of *"Our Islands Our Future"* and the *Islands Bill* create further scope to integrate the findings from the survey into island priorities around inclusion, social justice and community empowerment, as well as in relation to mental health service provision and (inter-island) transport.

The fact that the majority of the survey respondents are experiencing mental ill health issues whilst in employment is of great relevance for those policy and practice measures which seek to encourage people into meaningful, paid employment as a route to enhanced mental wellbeing. The survey findings are equally important when considering in-work support for those experiencing mental ill health. This new rural evidence will be of value to the Rural Economy and Connectivity portfolio of the Scottish Government, as well as to the specific Actions of the Mental Health Strategy around inclusive employment (Actions 36 and 37).

4. **Evidence**: Finally, the need for evidence is not a one-off, single requirement. This is recognised in the Mental Health Strategy, where the *Mental Health Strategy data framework* and *quality indicator profile* are being developed during the lifetime of the Strategy, with multi-dimensional measures (p.37). In producing this report, our on-going ambition is that the "six quality dimensions" of "person-centred, safe, effective, efficient, equitable and timely" can be seen through a rural lens, underpinned by this evidence from those across rural Scotland who are experiencing mental ill health.

The ultimate aim of this new rural evidence is to improve people's mental wellbeing. Although the numbers of these rural voices will always remain small, due simply to being a part of only one fifth of Scotland's population spread over 98% of its land mass, they nonetheless provide a compelling and authentic evidence base from which to build learning and tailored support.

Appendix 1: Summarised version of the survey questionnaire

Section I: About you

1. Please, can you tell us the first half of your postcode? E.g. TD7 or KW14.

2. What is your gender?

3. What is your age in years?

4. Do you live on your own?

5. Are you a carer?

6. What is your current employment status?

7. Please indicate your APPROXIMATE income.

8. In your own words, please describe your occupation. For example, you could say, 'I'm a teacher' or just 'teacher.' If you would like to be more specific you certainly may but please don't feel as if you have to be.

9. For each question below, please choose the box that best describes your experience over the **last 2 weeks.**
a. I've been feeling optimistic about the future
b. I've been feeling useful
c. I've been feeling relaxed
d. I've been feeling interested in other people
e. I've had energy to spare
f. I've been dealing with problems well
g. I've been thinking clearly
h. I've been feeling good about myself
i. I've been feeling close to other people
j. I've been feeling confident
k. I've been able to make up my own mind about things
l. I've been feeling loved
m. I've been interested in new things
n. I've been feeling cheerful

10. Are you doing any voluntary work?

11. Are you in receipt of Benefits?

12. How long has it been since your most recent visit with your healthcare provider regarding a mental health issue?

13. Do you suffer from any of the following issues related to mental health and wellbeing?	
a. Generalized anxiety disorder	b. Anorexia
c. Social anxiety disorder	d. Bulimia
e. Phobias	f. Binge eating disorder
g. Depression	h. Obsessive-compulsive disorder (OCD)
i. Bipolar disorder	j. Post-traumatic stress disorder (PTSD)
k. Schizophrenia/psychosis	l. Stress response syndrome or adjustment disorder
m. Dementia	n. Suicidal thoughts and feelings
o. Self-harming behaviour	

Section II: Public Transport and accessibility

14. Could you please tell us how much you agree with the following statements using a scale from 'Completely disagree' to 'Completely agree.'
a. I rely on public transport to access local facilities.
b. I rely on public transport to attend appointments or services that have to do with a mental health issue.
c. Public transport plays a critical role in my everyday life.
d. I spend a significant amount of time travelling on public transport that could be used for doing other things
e. I would use public transport more if I lived closer to an access point [train station, bus stop.
f. The current public transport in my area is unreliable.
g. It is difficult to plan routes for medical appointments because of where I live.
h. If I needed to attend an unplanned and non-urgent medical appointment on the following day, I would have no difficulty in planning a route to my destination using public transport.
i. The cost of using public transport to get to appointments is not a problem for me.

15. Using your best estimate, how many journeys would you say you make using public transport in a week?

16. In your opinion, would you say that public transport can often act as a barrier to receiving the proper care needed to manage your ill mental health?

About where you live

17. In your opinion, do you consider yourself to live in a geographically remote area?

18. If you marked 'yes' to the previous question, please could you tell us are there any advantages of living in a rural area to help your mental health? Are there any disadvantages?

a. Advantages about living in a remote area

b. Disadvantages about living in a remote area

19. If you marked 'no' to the previous question, thinking about where you live, what are some of the good things in terms of having a mental health illness? What are some of the bad things where you live in terms of having a mental health illness?

a. Good things about where you live

b. Bad things about where you live

20. Please rank the following facilities in terms of how accessible they are for you, starting with the facility which is easiest to access (1) to the facility which is most difficult to access.

21. How often do you receive service or care from the previously mentioned services or service providers?
a. My local GP
b. Physical health clinics
c. Hospital
d. Crisis team or crisis service
e. Community centre
f. Mental health resource centre
g. My carer
h. My local chemist or pharmacy

22. Where is your nearest mental health service facility?

23. Which word would you use to describe how you are treated by health service providers because of your mental ill health:

24. Have any local services that you used or relied upon ever been closed?

25. **If you chose yes to the previous question**, how did losing this service or facility affect your life?

a. What impact did this have on your mental health?

b. What did you do as a result (e.g. look for another service)?

Section III: The importance of my local community to me

26. As someone with a mental ill health, do you think you live in a supportive community?

27. If an urgent but non-life-threatening issue arose regarding your mental wellbeing, do you think you could rely on members of your community to assist you? Please don't include any medical service providers or carers when you think about your answer.
28. Who do you turn to when you need help?

29. Do you use a community or other centre to meet and socialise with other people with mental ill health?

30. How frequently do you meet and socialise with other people with mental ill health at a community or other type of centre?
31. Do you feel you can be open about your mental health problems in your community?

Section IV: What do I need from my local community?

32. Thinking about your own mental ill health, do you think it would be easier to manage if you moved to a different community?

33. If you could easily move to a new community, what would you look for that would help you manage your mental ill health?

a. Easier access to a GP	b. Easier access to a mental health resource centre
c. Easier access to a health clinic	d. Easier access to my carer
e. Easier access to a hospital	f. Easier access to a chemist or pharmacy
g. Easier access to a crisis team or crisis service	h. Peer support
i. Easier access to a community centre	

Section V: Anything else you want to tell us?

34. We now have three final questions for you . . .

a. If you could change ONE THING about mental health services in rural Scotland, what would that be and why?

b. What KEY MESSAGE do you want to tell policymakers to help you manage your mental ill health in a rural setting?

c. If you could change ONE THING about your life in rural Scotland, what would it be and why?

Appendix 2: List of 94 Postcode areas given by 296/343 respondents

P/cd	Location	P/cd	Location
AB21	Blackburn, Dyce, New Machar etc.	KA6	Dalrymple, etc. , East Ayrshire
AB22	Bridge of Don etc.	KA7	South Ayrshire
AB31	Banchory	KA8	Dalmilling, South Ayrshire
AB33	Alford	KA9	Prestwick, South Ayrshire
AB34	Aboyne	KA19	Maybole, South Ayrshire
AB35	Ballater	KA27	Darvel, East Ayrshire
AB36	Strathdon		
AB43	Crimond	KW1	Wick, Highland
AB45	Banff	KW3	Lybster, Highland
AB51	Inverurie	KW10	Golspie, Highland
AB53	Turrif	KW14	Thurso, Highland
AB54	Aberchirder, Cabrach, etc.	KW15	Kirkwall, Orkney
AB56	Buckie, Moray	KW16	Stromness, Orkney
		KW17	Rest of Orkney
DD8	Forfar, Glamis, Kirriemuir		
		KY2	Outside Kirkcaldy, Fife
DG1	Dumfries	KY10	Anstruther, Fife
DG2	Dumfries	KY13	Kinross-shire
DG3	Thornhill	KY14	Cupar, Fife
DG5	Dalbeattie, Kirkcudbrightshire		
DG6	Kirkcudbright	PA7	Bishopton, Renfrewshire
DG7	Castle Douglas, Kirkcudbrightshire	PA20	Isle of Bute
DG8	Newton Stewart, Wigtownshire	PA23	Dunoon, Argyllshire
DG9	Stranraer, Wigtownshire	PA34	Oban, Argyllshire
DG10	Moffat, Dumfriesshire	PA43	Isle of Islay
DG11	Lockerbie, Dumfriesshire	PA66	Isle of Mull
DG12	Annan, Dumfriesshire	PA73	Ulva Ferry, Isle of Mull
DG13	Langholm	PA76	Isle of Iona, Argyllshire
DG16	Gretna, Dumfriesshire		
		PH1	Perth
EH16	Liberton	PH4	Blackford, Perth and Kinross
EH19	Bonnyrig	PH10	Blairgowrie, P&K
EH34	Pencaitland	PH11	Alyth, P&K
		PH26	Grantown-on-Spey, Highland
FK11	Menstrie	PH33	Fort William, Highland
		PH36	Acharacle
HS1	Stornoway, W. Isles	PH41	Knoydart
HS2	Isle of Lewis		
HS3	Isle of Harries	TD2	Lauder, Scottish Borders
HS9	Isle of Barra	TD6	Melrose, Scottish Borders
		TD7	Selkirk, Scottish Borders
IV2	Culloden etc.	TD8	Jedburgh, Scottish Borders
IV6	Muir of Ord etc.	TD9	Hawick, Scottish Borders
IV7	Conon Bridge, Culbokie	TD12	Coldstream, Scottish Borders

IV17	Alness, Highland	TD14	Eyemouth, Berwickshire
IV18	Invergordon, Highland		
IV19	Tain, Highland	ZE1	Lerwick
IV22	Achnasheen	ZE2	Rest of Shetland (excluding Bush)
IV25	Dornoch	ZE3	Bush, Shetland
IV26	Ullapool		
IV30	Elgin, Moray		
IV31	Lossiemouth, Moray		
IV36	Forres, Moray		
IV47	Isle of Skye, Highland		
IV51	Portree, Highland		
IV54	Applecross, Highland		
IV63	Drumnadrochit etc., Highland		

Appendix 3: National Rural Mental Health Forum – Membership List and Contact Point

Acumen

Audit Scotland

Forestry Commission Scotland

LEADER Dumfries and Galloway

Moray Wellbeing Hub

National Farmers' Union of Scotland

NHS Grampian Public Health

NHS Health Scotland

Royal Highland and Agricultural Society of Scotland

RSABI

RSPB

Rural Housing Scotland

Samaritans

Scotland's Rural College (SRUC)

Scottish Association of Young Farmers' Clubs

Scottish Government Health Workforce

Scottish Government Rural Communities Policy Team

Scottish Churches Rural Group

Scottish Land and Estates

Spirit Advocacy (HUG – Highland Users Group)

Support in Mind Scotland

Contact: Jim Hume (Convenor/Manager of Forum): jhume@supportinmindscotland.org.uk