Lost in Space:

Shropshire Rural Mental Health

in an Age of Austerity

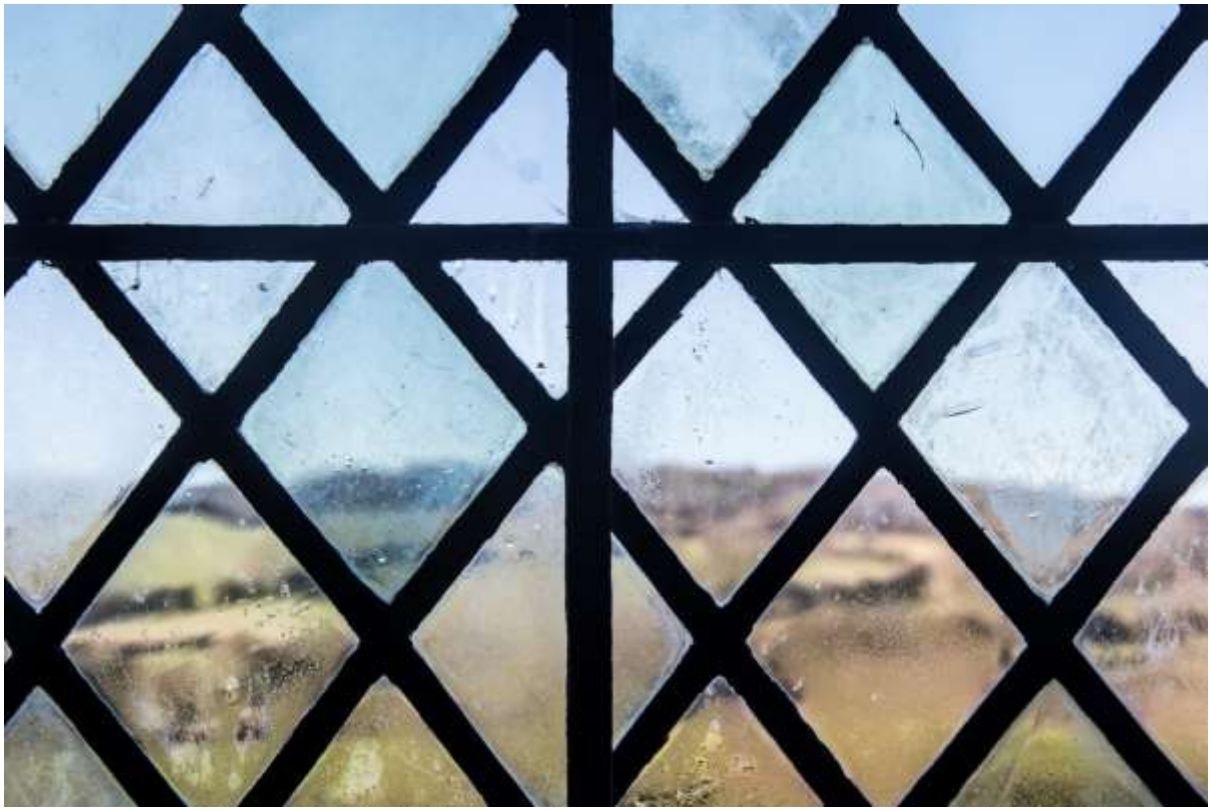
This project has been supported by *Healthwatch Shropshire* Research Grant funding. The report was written by Aislinn Bergin, Tim Lewington and Jean Nicholls. The project was completed by the Patient and Carer Experience – Research, an independent group of volunteers made up of service users and carers associated with the Research and Innovation Department of Midlands Partnership Foundation Trust.

November, 2018.

"…there was no one about except for cows and sheep." Service User 2.

"The minute something happens everybody knows." Carer 2.

"Things are ok so long as you can drive in Shropshire." Clinician 6.



The photographs in this report appear courtesy of Tottie Aarvold who retains all copyright privileges. Tottie Aarvold is a Fine Art Photographer based in Ludlow, Shropshire and specialises in psychologically complex landscapes and close-ups which often capture the ambiguous atmosphere of rural thresholds and abandoned dwellings. This is a view from Stokesay Castle in Shropshire.

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Foreword

This study was conceived and carried out by the Patient and Carer Experience: Research (PACE-R) with support from Dr. Tim Lewington. PACE-R is a group of service users and carers who are interested in research and getting involved in a variety of research activities. The group is supported by the Research and Innovation Department of the Midlands Partnership NHS Foundation Trust. The group, which began in early 2015, meets quarterly and contributes expertise by experience to a variety of projects and research activities. A senior member of the group, Jean Nicholls led the project for the PACE-R group and worked on all aspects of the conception, design, development, data collection, thematic analysis, report-writing and dissemination. Other members of the group contributed to the literature review and thematic analysis.

In response to an invitation to submit research proposals to *Healthwatch Shropshire* in September 2016, PACE-R developed a proposal to explore the experience of rurally-based mental health service users with a serious mental illness, their carers and clinicians. Using qualitative techniques` (a focus group with service users, a focus group with carers and individual interviews with clinicians) we were able to assemble a picture of rural life experienced by Shropshire service users with a serious mental illness and their carers as well as identifying the particular barriers and challenges faced by them which are unique to or exacerbated by their rural location. Clinicians contributed an understanding of the contemporary challenges faced when delivering mental health services across a large, predominantly rural county.

We partnered with *Shropshire Mind* to undertake the study and we are grateful for their invaluable input, use of their premises to hold the focus groups and for introducing us and allowing us to recruit one of their Board members and researchers, Aislinn Bergin, to work on this project. Aislinn has provided invaluable services which have driven the project forward to completion, including transcribing the focus groups and interviews, contributing to their thematic analysis as well as helping to write up the final report. Aislinn also found time to complete her Ph.D., while working on the project and we wish her well in her future research endeavours.

Introduction

There has been a cultural shift over the last decade in attitudes towards mental health and mental illness. *Mind's* often cited statistic that 1 in 4 people will experience a mental health problem in any particular year and the "Time to Change" campaign to end mental health discrimination (led by *Mind* and *Rethink Mental Illness*) have done much to change perceptions and raise awareness of how common and widespread mental ill health is. The government has recognised that mental health needs have been under-resourced for a long time and that parity of esteem needs to be established between physical health and mental health. While there is more awareness and coverage in the media and a greater acceptance of mental health conditions by the public at large, multiple problems remain. Despite the goal of parity of esteem within the NHS, evidence suggests mental health services remain underfunded.[1] Since the financial crisis of 2007-09 significant welfare cuts and the introduction of Universal Credit have led to increased hardship for people with disabilities, perhaps especially for those with mental health difficulties.[2] As the government has pursued policies of austerity and retrenchment of public services, services which previously supported the wellness of mental health service users as well as services to help carers have been subject to successive rounds of cuts. As national budgets have shrunk much of the burden of this shrinkage has been passed on to local governments; the Local Government Association notes the current cut to the local government core funding since 2010 stands at 49% and this is due to become a 77% reduction by 2020.[3] Shropshire County Council's projected budget deficit for 2018-19 stands at over £20 million and the county projects a deficit of nearly £60million by 2022-23.[4] Without a reversal of central government cuts, local government

[1] See Royal College of Psychiatrists (2018) "Mental health trusts' income lower than in 2011-12." Available at: https://www.rcpsych.ac.uk/mediacentre/pressreleases2018/mentalhealthtrustincome.aspx
[2] For problems with the new UC see National Audit Office (15/06/2018) "Rolling out Universal Credit." Available at: https://www.nao.org.uk/wp-content/uploads/2018/06/Rolling-out-Universal-Credit.pdf
[3] *Financial Times* (04/07/2017) "Local councils to see central funding fall 77% by 2020." Available at: https://www.ft.com/content/9c6b5284-6000-11e7-91a7-502f7ee26895
[4] *Shropshire Star* (15/02/18) "Shropshire Council saving £43 million to balance budgets." It should be noted that Shropshire is far from alone in experiencing such budgetary difficulties.

services will see further retrenchment. These cuts to local services have contributed to a widening of health inequalities across the country (Local Government Association, 2017) and rural areas have been particularly hard hit as remaining services become concentrated in larger urban centres. The Shropshire Clinical Commissioning Group (CCG) is also reporting a current deficit of over £13 million and needs to make a further £99 million of savings over the next 5 years.[5]

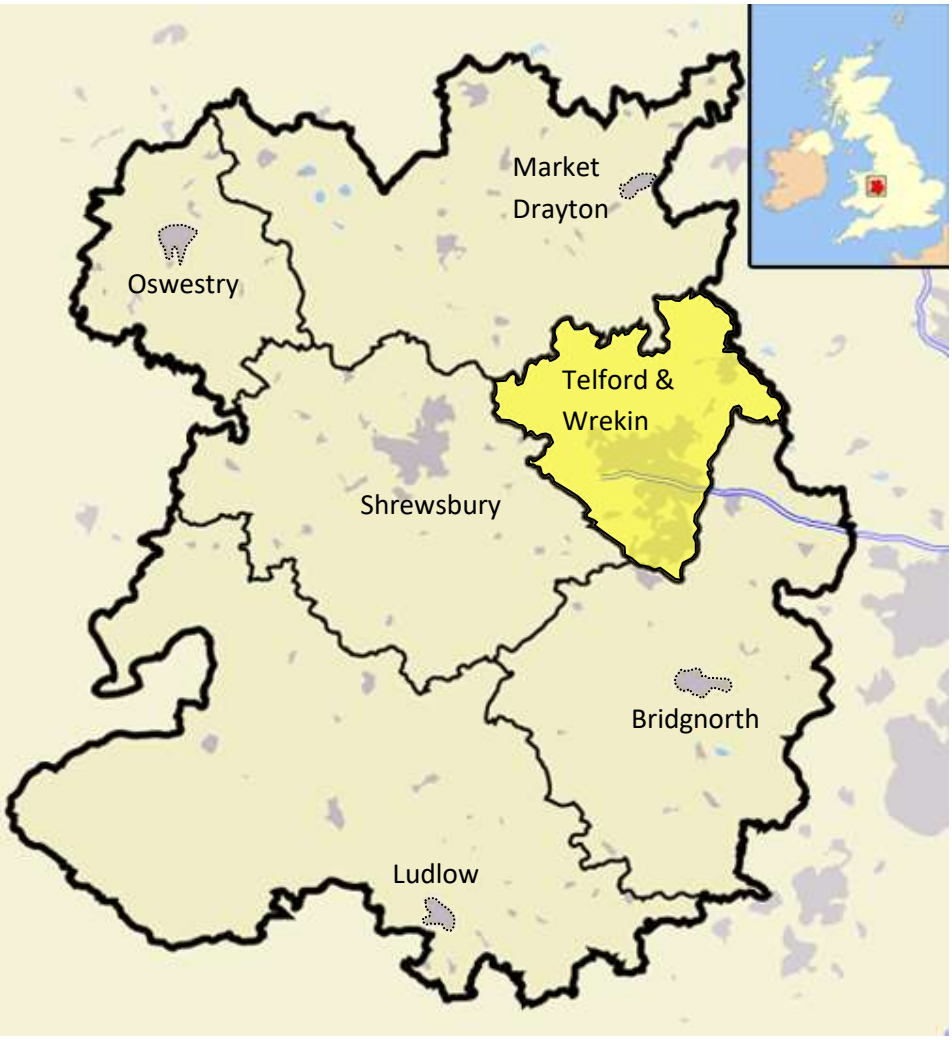
Reductions in public transportation subsidies for bus routes have compounded the lack of access to services, job opportunities or simply people's ability to get around. Rural bus routes have been particularly hard hit leaving some already vulnerable people, especially those without access to a car, in an increasingly isolated situation. Shropshire's predominantly rural character makes it particularly vulnerable to such cuts; a recent *BBC* investigation found Shropshire's bus miles had been reduced by over 20% in just the four years from 2013 to 2017. This level of route reduction can have major consequences for individual communities: "Villagers in Ditton Priors, Shropshire, who have not had a regular bus service since 2012, say some elderly residents have been forced to move away." [6] Other low income or vulnerable residents, such as those with a serious mental health condition are likely to have experienced a similar level of social exclusion.

There is often a tendency to downplay or overlook the health and mental health needs of rural areas. A romanticised view of a peculiarly English rural idyll predominates and it is all too easy to generalise from well-heeled suburbs and commuter villages to encompass entire counties. Rural areas are associated with a culture of stoicism and self-reliance; rural poverty is all too often hidden, or at least not obvious. At the census of 2011 over half of Shropshire's population of 314,000 lived in rural areas (175,469). The county's largest urban area, the centrally located town of Shrewsbury dominates the urban hierarchy (with a population just over 70,000); much of the rest of the county is predominantly rural in character with a widely dispersed population. Four small historic market towns anchor the settlement structure in each of the 'corners' of the county, they are; Ludlow and Oswestry to the West; Market Drayton and Bridgnorth to the East (see map, below; a fifth settlement,

[5] See *Newport Advertiser* (16/08/2018: p.6) "£60 million health group deficit 'may take 15 years to clear.'"
[6] *BBC* (16/02/2018) "Britain's bus coverage hits 28-year low." Available at: https://www.bbc.co.uk/news/uk-england-42749973
See also Campaign for Better Transport (2018) "Buses in Crisis: A report on bus funding across England and Wales 2010 – 2018." Available at: https://bettertransport.org.uk/sites/default/files/research-files/Buses-in-Crisis-2018_0.pdf

Whitchurch in the very north of the county, failed to meet the threshold for urban classification in 2011).

Figure 1: Map of Shropshire, Telford & Wrekin. In 1998 The Wrekin joined with Telford to form a metropolitan borough (marked in yellow) and shares some local government functions with the Ceremonial County of Shropshire.



SOURCE: Adapted from Wikimedia Commons.

For the purposes of this study we are focussing on the rural areas outside Shrewsbury which constitute the bulk of the county and have effectively excluded Telford (as it is a metropolitan borough; furthermore, a separate *Healthwatch* covers the Telford area). While Telford is predominantly a conurbation (a classic late 1960s New Town which was partially built on greenfield sites but also incorporated existing communities such as Ironbridge, Wellington,

Madeley and Donnington) some areas are nevertheless quite rural in character, particularly along the northern fringe. This illustrates a problem inherent in the definition of rural, an issue which is explored below.

1.1 Defining 'Rural'

In practical terms there is a continuum which runs from extreme rural to comprehensively urban; the formal definition of rural begins with a settlement size of below 10,000 inhabitants (DCLG, 2001). No one method of delineating city from countryside however satisfies all needs and the relationship between town and countryside has been historically fraught and problematic. Whatever definition is chosen grey areas and exceptions remain and the distinction between rural and urban is never easy to delineate nor is it clear-cut (Bibby & Brindley 2013). For example, a rural village in a Green Belt home county thirty minutes by train from London may well fit the formal definition of rural but if most of the inhabitants commute daily to jobs in the City then functionally the village looks distinctly urban in orientation. In this case the City is 'under-bounded' – that is, its functional boundary extends far beyond its legal boundary to include significant commuter watersheds and other areas of influence. Shrewsbury exerts a similar influence on its surrounding rural areas (not least because the next largest town is so much further down the urban hierarchy).

For England and Wales the Office of National Statistics (ONS) have accommodated these complications by drawing a distinction between rural and urban settlements based on population density and on the degree to which these communities are located in 'sparse' geographic contexts (both Northern Ireland and Scotland employ different definitions of rural). The ONS's more nuanced classification identifies 'hub towns' of between 10 to 30 thousand inhabitants which serve a wider, relatively sparsely populated rural hinterland. All four market towns in Shropshire meet this definition of 'rural related.' At a higher level of aggregation, the rural or urban character of different Local Authorities (LA) can then be distinguished by settlement patterns set their wider contexts.[7] This results in three

[7] A formal definition can be found at Defra (2014) "2011 Rural-Urban Classification of Local Authority and other higher level geographies for statistical purposes" available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/307939/2011_Rural-urban_statistical_classification_for_local_authorities__interim_results_-_hub_towns_.pdf
Defra has produced two useful leaflets describing this classification which can be found here: https://www.ons.gov.uk/file?uri=/methodology/geography/geographicalproducts/ruralurbanclassifications/2011ruralurbanclassification/rucladleafletmay2015tcm77406355.pdf and: https://www.ons.gov.uk/file?uri=/methodology/geography/geographicalproducts/ruralurbanclassifications/2011ruralurbanclassification/rucoaleafletmay2015tcm77406351.pdf

predominantly urban and three predominantly rural LA classifications where the latter has more than half of its population living in rural areas or rural-related hub towns. These Rural LAs have three sub-types: urban with significant rural (these tend to be on the fringes of the larger conurbations); largely rural (population between 50% and 79% rural including hub towns) and mainly rural (with greater than 80% of the population in rural areas or hub towns). Shropshire falls firmly into the "largely rural" category with a total rural and rural related population of 229,157 at the last census in 2011, or 75% of the total.

1.2 Research on Rural Mental Health

The mid-2016 population estimate for England reports a rural population of 9.37 million which equates to 17% of the 55.2 million total population.[8] In general the rural population is older and healthier than urban dwellers and enjoys a slightly longer life expectancy; life-satisfaction is slightly higher and anxiety levels slightly lower.[9]

International comparisons of mental health incidence and prevalence are hard enough to undertake and to account for all the cultural variations embedded in different national urban structures only compounds the problem (consider the different definitions of 'rurality' employed across the United Kingdom). However, "…research would suggest that mental health is probably better in rural areas" (Nicholson, 2008: 305) though the differences can be slight and can pale beside other factors such as age, gender or degree of economic and social deprivation (Gregorie & Thornicroft, 1998). For some serious mental health conditions, most particularly psychosis, a clear and long standing epidemiological relationship has been established, though the underlying causes of higher incidence in urban areas has yet to be determined (see the meta-analysis of evidence conducted by Vassos *et. al.*, 2012; Lederbogen *et. al.*, 2011; see also Kirkbride *et. al*., 2014 for the implications for service delivery). To complicate the picture there is some evidence to suggest that mental ill health is systematically under-diagnosed in rural areas as stigma leads to underreporting of symptoms by the patient which can then be reinforced when a higher clinical threshold of symptoms is expected to justify the expense and complication of referral for assessment and treatment in often distant urban areas (see Kvig *et. al*., 2017 for Norwegian evidence; Polaha *et. al.*, 2015

[8] Defra (2018) Statistical Digest of Rural England (June), p.11. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/720231/04_Statistical_Digest_of_Rural_England_2018_June_edition.pdf

[9] *Ibid*, p.168ff.

for the case of the USA; Donaghy, 2012 for an example from the UK). As Nicholson (2008: 302) notes, professional structures and the organisation of service delivery can also be important factors which reinforce an implicit urban bias:

> "Although it is not often thought of in these terms, psychiatry in the UK is,… a predominantly urban specialty. Large units and inpatient facilities are usually based in cities, services serving rural communities are centralised as far as is possible. Psychiatric research is almost entirely conducted on urban populations,…"

This urban bias may be compounded by shortages of skilled staff willing to work in remote rural areas as well as higher costs for rural services. DEFRA (2011: 12) reviewed the evidence for inequalities in health outcomes in rural areas and concluded:

> "Asthana *et al*. (2003) state that there are cost variations associated with providing services for urban and rural areas and particular problems relating to economies of scale, travel cost, unproductive time and staffing issues. In terms of resource allocation, it is argued that adjustments need to be made to take account of differing needs in rural areas (Asthana *et al*., 2003).

Large scale studies investigating the state of rural mental health tend to be infrequent and their geographic coverage patchy. Between 2001 and 2003 Scottish geographer Chris Philo and colleagues completed a large scale study of inclusion and exclusion experienced by mental health service users in four areas of the rural and remote Scotland Highlands (Philo Parr and Burns 2003a; 2003b). Since then there have been some useful large-scale surveys focusing on the experience of rurally-based mental health service users in the peripheral countries of the United Kingdom: Northern Ireland (2011), Wales (2017), and Scotland (2017). In England, case-studies have been produced by the Local Government Association in concert with Public Health England (2017) accompanied by a report into the State of Rural Services (2016). In order to sketch a crude national picture these reports will be reviewed in turn before focussing on some background statistics for Shropshire which help set the scene and provide context for the results section which follows.

The Patient and Client Council of Northern Ireland undertook a large-scale survey (with almost 1,500 responses) looking at the general health and social care needs of rural residents (the survey covered but was not specific to mental health) and published their findings in 2011 as "Rural Voices Matter." Respondents "stressed the need to retain local services, reduce waiting times, and improve the quality of care" (Patient and Client Council, 2011: 5). Further,

> "Rural dwellers are concerned about waiting times for hospital care and treatment. 596 people ticked 'waiting times' as an area of concern; and many others cited it as their second area of concern. Lack of services in rural areas, appointment systems, access to services, quality of services, awareness of or information about services and location of services were the main areas of concern across Northern Ireland."

The report recommended rural proofing of all relevant government policies in Northern Ireland, a process which would identify the impacts of a policy on rural areas; assess the significance of such impacts; and make suitable adjustments to the policy to accommodate the health and social care needs in rural areas.

In 2016 Support in Mind Scotland and the Rural Policy Centre conducted a paper and electronic survey of rurally-based mental health service users to coincide with the updating of Scotland's Mental Health Strategy. A total of 343 responses were received, with a large response rate from people with depression and anxiety. Two broad themes emerged relating to rural isolation and service provision. People reported feeling remote and socially isolated (including those living in 'accessible remote' and remote small towns, two settlement classifications used in Scotland). This isolation was compounded by public transportation issues which acted as a barrier to accessing mental health services. The report concluded "[t]his can lead to a 'layering' of isolation factors" (Skerratt, Meador & Spencer 2017: 6). There was little ambiguity about community support with respondents reporting that their local community was either strong and supportive or parochial and judgemental, but "[t]he majority of respondents do *not* feel they can be open about their mental health problems in their community." (*ibid;* emphasis in original). Asked to identify one aspect of mental health service provision they would change if they could, respondents wanted opportunities to build low-level, non-clinical and informal social connections prior to the onset of personal crises; and for services to be close by and accessible (especially for those living on the West Coast Islands). These preferences coincide with and potentially reinforce the wider tendency in the NHS to provide more and more services in the community as close to the patient as possible, though it also indicates how complex this can be for mental health illnesses where stigma and discrimination are still prevalent.

A Welsh rural health planning and consultation exercise in 2009 designed to improve rural health and social care service delivery, identified three broad areas needing attention; access, integration and community cohesion. The consultation recommended reinvigorating "community hospitals, which fully exploits their potential to bring services closer to rural communities" (Welsh Assembly, 2009: 3) and, for mental health, addressing specific issues

such as the transition from hospital care to the community (*ibid:* 21). The Welsh Assembly subsequently published a comprehensive 10-year Mental Health Strategy in 2012. This strategy focusses on all age groups and conditions, seeks to integrate services and is designed to boost individual and community resilience. Where the planning consultation identified the need to bring services closer to rural communities (2009: 3) via community hospitals and even pharmacies, the emphasis in the Strategy and related delivery documents shifts to transportation: "Improving transport is a key issue, particularly where even "local services" may be many miles away. Health Boards and Local Authorities need to develop innovative approaches such as telemedicine and mobile outreach services to improve access" (Welsh Government, 2012: 57). The rural population of Wales (about one third) is much higher than England (under a fifth) so it is perhaps odd that the term 'rural' only appears 5 times in the 75-page Strategy. The Mental Health Foundation (2017: 15), monitoring the progress of the strategy in 2017 found that:

> "Lack of services available to support people with mental health problems and early intervention services is an issue throughout Wales, but particularly in rural Wales, where significant gaps in services exist. Research has found that distance alone is an important factor when it comes to maintaining and improving health."

For England, the Local Government Association (LGA) together with Public Health England (PHE) published a group of case studies in 2017, arguing that conventional statistics often hide small pockets of poverty and deprivation which can have a significant impact on people's health in rural areas. This approach avoids broad geographic generalisations about rural areas in favour of a more fine-grained, detailed and place-based approach which has the potential to build "on the strengths of public health and on the reach and influence of local government's many other functions" (Local Government Association, 2017: 5) The wider social and economic determinants of health are still important of course (especially poverty, housing, employment and transportation) but these react with and compound other issues such as demographic changes (in particular, an aging population in rural areas); a widening gap in digital infrastructure in rural areas; poorer access to health and social care services (compounded by greater distances which need to be travelled to access these); and 'community support, isolation and social exclusion' (*ibid* 2017: 7-8). A place-based approach acknowledges the multi-factorial nature of health issues in rural areas and has the potential to differentiate small-scale pockets of isolated poverty and deprivation which can stress rural micro-populations – it also has the potential to account more fully for vulnerable,

at-risk groups such as migrant farm workers, travellers and the rural homeless.[10] Using the index of multiple deprivation the LGA-PHE report highlights areas of rural Shropshire around Oswestry in the North, the Western fringe adjacent to Powys and large parts of the Southern tier of the County which are more deprived than average by this measure (see their map on p.11). In reviewing the provision of mental health services, Rural England (2017: 60) found them to be highly variable at the local level.

We have already noted that Shropshire's population is predominantly rural. At the 2011 Census Shropshire's population was split: 130,660 urban and 175,500 rural and the overall population is predicted to increase to 320,600 by 2020 (Shropshire Telford & Wrekin 2016: 7). Shropshire's population is aging too and this has implications for service delivery in the county, addressed in the new *Sustainability and Transformation Plan* (p.9):

> "The welcome improvement in the life expectancy of older people is particularly pronounced in Shropshire where the population over 65 has increased by 25% in just 10 years. This means the pattern of demand for services has shifted with greater need for services that support frailer people, often with multiple long-term conditions."

Shropshire has a lower proportion of the population living in the most deprived areas, though pockets of deprivation remain in both rural and urban areas – though the extremes are more pronounced in neighbouring Telford & Wrekin (Public Health England, 2018). Life expectancy for both genders is higher in Shropshire than the national average but within the county, life expectancy is 3.7 years lower for males and 2.5 years lower for females in the most deprived areas compared to the least deprived (*ibid* p.3).

1.3 Methodology

Following a review of the literature it was decided to focus attention on rurally-based people with a diagnosis of serious and enduring mental illness (principally psychosis and Bipolar Disorder) as 'rurality' would likely have the biggest impact on these conditions. After a low response was received from an initial round of publicity the eligibility criteria were widened to include severe depression. Eligibility for the carer focus group included family members and others with experience of caring for someone with a mental health condition in a rural area. Carers need not be related and no familial or other connection was required with service

[10] Rural homelessness is a surprising large and practically invisible group; see the recent report by the IPPR (2017) *Right to Home: Rethinking Homelessness in Rural Communities.* Available from: https://www.ippr.org/files/2017-06/1498563647_right-to-home-a4-report-170627.pdf

user participants on the study. The carer focus group took place on 27th July 2017 followed by the service user focus group on August 10th.

To accommodate the multi-factorial, complex nature of mental health conditions in rural areas a predominantly qualitative approach was adopted. We anticipated that there would be multiple perspectives on the many relevant, interconnected issues so we arranged two focus groups, one with service users and one with carers. After considerable discussion around the choice of location for these meetings it was decided to use the *Shropshire Mind* headquarters in Shrewsbury. It may appear ironic to hold focus groups seeking to explore the experience of rural mental health in a large urban area but the entire transport infrastructure (both road, rail and bus routes) is orientated towards the town of Shrewsbury which is itself central-located in the middle of the county (see Figure 1 on page 7). Choosing a location in a rural area outside the town would have been convenient for rural participants close by but would have doubly inconvenienced participants from the opposite side of the county (who would have had to travel through or around Shrewsbury, perhaps by multiple modes of transport). In a larger project this obstacle could have been overcome by holding more than one focus group but this was not a practical option in this case. The focus groups lasted a little under three hours (with a tea break about half way through) and participants received £20 for their involvement and travel expenses were reimbursed.

The perspective of clinicians was garnered through a series of semi-structured interviews conducted by Jean Nicholls. An interview schedule was prepared and trialled with a 'mock' interview with another researcher unconnected with the project. In total, ten clinicians were interviewed, including a rurally-based GP; each interview lasted about 30 minutes.

Transcripts of the focus groups and clinician interviews were generated and anonymised by Aislinn Bergin before being subject to thematic analysis after Braun & Clarke (2006). This was completed by the three principal researchers in addition to volunteers from the PACE-R group and two other volunteers from the Research and Innovation Department. The themes were then aggregated and are the basis for the narrative account which follows.

Limitations of the study:

Despite distributing promotional material at a variety of locations across the county, widening the eligibility criteria and even appealing for volunteers on *BBC Radio Shropshire's* drive time radio programme, attendance at the focus groups was small (a total of 9 participants across both focus groups). Overall 19 people (10 clinicians) contributed.

Rurality and Mental Health in Shropshire:

Results

In the following we explore the themes to emerge from the two focus groups and ten clinician interviews. Many of these themes are interrelated and intertwined; this poses a particular challenge for their presentation. We have chosen to avoid an approach based on reducing these themes to isolated elements which would describe how each of these are viewed by first service users, then by carers and then by clinicians. Instead we have adopted a narrative form which allows connections between themes to be drawn out. This does involve a certain amount of repetition but ensures the interconnections are mapped and due attention is paid to factors which reinforce one another (for example, rural isolation is compounded by cutbacks to public transportation, poor rural digital infrastructure, changes to welfare provision, changes to service provision and so on). As with the provision of mental health services generally, where a holistic perspective is needed, so with our account of rural mental health in Shropshire.

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2.1 The Experience of Rural Mental Health Services

While it is not possible to paint a comprehensive picture of all the lives of rurally-based service users with a serious and enduring mental health condition in Shropshire and their carers; our aim here is to provide a picture which highlights the difficulties and challenges faced in rural areas. We make no claims that this experience will necessarily reflect the experiences of all rurally-based mental health service users and their carers (individual and social circumstances vary widely after all). However, at an abstract level some experiences are likely to be common amongst all service users living in a rural area (access to public transportation or digital infrastructure, for example). It should also be noted that participants in both focus groups discussed both specific and more general issues based on the totality of their experiences. While all of the service users were living in a rural area of Shropshire at the time of the focus group for example, they each had experience of living in a variety of locations along the rural – urban continuum, from tiny hamlet to large cities. They therefore reflected upon and made comparative assessments across these geographic contexts. Some had experienced living in large cities and found this difficult; "I'm not keen on lots of people through paranoia" and "… there was loads [to do] but it was too busy" (Service User 1). While all the service users were settled in their current, rural locations with support from their families, this had taken many years to achieve after unsatisfactory attempts:

> "… [following treatment in Shrewsbury] they offered me a place in a rural village and I went there for about four months and I hated it. I wanted to get away from there and it took them about a year and a half to get me out of there." (Service User 1).

There was clearly a process of experimentation and a search for a geographic context which 'worked' for the needs of the service user at both the particular point in their life-cycle and in relation to their mental health condition (in particular, different phases of crisis, recovery and remission, or relapse). Attributes associated with particular locations assumed more or less significance depending on age and degree of wellness. For example, the anonymity of large urban areas was seen as a positive attribute in a period of crisis – the attendance by the ambulance or police service would not be noticed so much and any associated stigma would not be so long-lasting. Based on experience, extremely rural locations were identified as negative: "it was the middle of nowhere,… there was no-one about except for cows and sheep" (Service User 2). Some sort of implicit balance based on the size and attributes of community was being sought:

> "I think if you have had any mental issues, communicating with other people, talking to other people becomes very difficult. You become very introverted and if you know it just makes it a doubly difficult problem if you haven't got that community around you. Sometimes you have to make the effort to go out and talk to people yourself but if you've got issues it's hard to do." (Service User 4).

It was recognised that the term 'community' was problematic:

> "Just because it's a rural area doesn't mean to say that everybody does look out for everybody else. I think it comes down to having a good community, if everybody tries to help each other and they actually interact with each other, if it's a town or a village. I've lived in rural areas where people just keep themselves to themselves so you're no better off." (Service User 4).

Although some of the service users had experience of very isolated rural living this was not popular and most had migrated towards Shropshire's larger rural communities (still with populations of less than or near 10,000). Here, there was a sufficient concentration of people and social resources such that opportunities for social interaction were available, a community could be constructed with fellow service users and sufficient activities could be found to alleviate boredom without risking over-stimulation. Support from family was also available: "I live with my mum and she looks after me" (Service User 3).

eHealth Resources:

Much has been made of the potential for digital resources both to enhance clinical treatment and improve the quality of life of people with mental health conditions. Participants of the service user focus group were broadly middle-aged and were uniformly uninterested in computers and their potential. Four representative quotes reinforce the point:

> "I don't have anything to do with computers unless it's to play tunes. That's it."

> "I think online is difficult because I don't want to give too much. I don't want to give too much away because you don't know… who you're talking to" (Service User 3).

> "You need to feel happy that the person you're talking to [online] is understanding really." (Service User 4).

> "Bit too technical for me. No, I don't go on computers really. Can barely work my phone let alone my computer!" (Service User 1).

The development of rural digital infrastructure is already lagging far behind urban areas and its potential to deliver enhanced health and social care services will be further limited by a reluctance to use this resource by some mental health service users (especially those who are socially isolated or prone to paranoia). Lack of resources may also hold back rurally-based service users taking up health-related apps, video-conferencing and the like which require relatively new and high-powered computer devices and infrastructure to function effectively. For this group of service users at least, digital resources were under-used and seen to be of little value; there was a distinct preference instead for face-to-face social interactions. A greater emphasis on digital forms of healthcare delivery many well require training and support for rurally-based service users for them to be able to take full advantage of this delivery method. By contrast, carers were much more willing to use computers and recognised the value of the internet despite a number of them reporting difficulties with rural infrastructure: "I don't have the internet, I use the library where it's bad enough" (Carer 4). Carers nevertheless viewed the internet as both a vital local tool to communicate regularly with a network of other carers: "the internet for me is vital and I support other carers through email. I couldn't do that through the phone" (Carer 2) and as a global source of relevant information: "it's a goldmine of information. Information from all over the world" (Carer 1).

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Psychosocial Aspects of Mental Health:

The focus group participants took part in a variety of leisure, social and learning activities. Some of these activities were self-initiated:

> "I'm never short of things to do. I play football, I swim every day, I have a choice of going to the gym (but I'm not doing that at the moment). I did used to do circuit training but I found that too hard going because I got out every weekend and I dance most of the night." (Service User 3).

Some activities were available in the community (though not everyone had access to such community resources):

> "I go to the [cottage] hospital which is about a mile from my house. They've also got a community centre next to it and I spend a lot of time there doing various things. Like a cookery group. I think it's lottery funded. It's like a community centre and they have computers there and art groups, all sorts, even a yoga group going on there." (Service User 3).

Another service user travelled weekly to Shrewsbury by bus to play Bingo: "[It] gives me something to do in the week. I've got a free bus pass and you can play for free there as well. Just a day out, I go every week and enjoy it" (Service User 1). While the service users made use of community and some commercial resources or activities, carers noted the cutbacks to support services which were previously supplied by the NHS or the local authority:

> "My main gripe is that there used to be somebody who would come and go out on a walk with my son or there used to be a football [game], his care plan noted that he liked football. So he used to play in Craven Arms but with the cutbacks all of that is gone so the care plan is irrelevant. Now if we lived in Shrewsbury he could join [a] five-a-side football team. So my main gripe is that the things that would enable his recovery are too far away or one can spend the whole day travelling to get there for half an hour and maybe it's just too much when someone is unwell to spend the whole day on public transport to go and play football." (Carer 3).

The withdrawal of support for social activities which previously supported recovery and the maintenance of wellness has shifted the focus of service delivery: "I think all the services have been cut to the bare bone so that we're delivering, well we're all more or less delivering a crisis service now rather than recovery" (Clinician 2). What resources remain following successive rounds of cuts tend to be concentrated in urban areas:

> "In a city there will be more resources,… funding is targeted to meet the maximum number of people as possible so it's not cost effective to give lots of services in a small community when say five people might use it." (Clinician 2).

Employment:

While one of the service users worked full time; others did voluntary work in a variety of settings (though charity shops featured prominently). This activity was tied to the benefits system and presented some with a challenge; while stimulating and building capacities, volunteering could also inadvertently demonstrate capabilities which might result in a reduction of benefit payments when re-assessed: "A few years ago [assessors for the Department of Work and Pensions] said to me 'touch your nose' and then they went and talked to my mum and then I lost £50 a week. I'd like to [volunteer] but if they find out I'm not as stupid as they think I am the money goes down" (Service User 2). Previous forays into the formal workforce in competitive, paid positions had proved unsuccessful (despite being arranged by Enable, the supported employment service part-funded by Shropshire County Council):

> "I was doing cake filling, making the mixes for cakes. And I wasn't very good at it and I made too much mess, I was hopeless at the paperwork. Put the wrong ingredients in. [The foreman] kept telling me off all the time and I was there I'm not gonna lose my temper, I'm not gonna lose my temper. Then in the end I said, "Ah, I can't do this" and [the foreman] said "no, you can't." So that was the end of my career as a cake filler!" (Service User 3).

Amongst the group as a whole there was a general sense of acceptance of their lot in life – a passivity and stoicism to which we will return later. One service user on Employment and Support Allowance acknowledged this openly: "I'm not interested in a job. No, I'm comfortable as I am. If I had a job I wouldn't be able to go to the gym every day and I wouldn't be able to go to various groups and all that sort of stuff. But if they put me on Jobseekers then I'd have to look for a job and it would cause me problems because there is no work where I live" (Service User3). For service users settled in larger rural communities, close to family and with routine social, leisure and volunteering activities readily available, moving to competitive employment may well require substantial support from employment services, community mental health services and could also involve leaving this community and support network to seek employment elsewhere. Mobility beyond the local community was an issue for many; only one of the service users had a car; the others either had never learnt to drive, no longer had licences (as a result of Mental Health Act Sections) or couldn't afford to buy and run a vehicle: "It's expensive isn't it? MOT, insurance, anything goes wrong with it. Loads of money" (Service User 3). Cuts to rural bus services also limit areas available for possible employment opportunities within easily commutable distance by public transport.

2.2 The Impact of Austerity

A decade of austerity has had a variety of impacts on both mental health patients, their carers and on the services on which they rely. Cuts to welfare and changes to the how the welfare system is administered (the migration to Universal Credit and the regular re-assessment by private companies of recipients' eligibility, and so on) have resulted in real hardship for many mental health service users, and this in turn impacts on their wellness and their ability to manage and maintain a state of well-being in the community:

> "The austerity drives recently and the rejection of people's personal independence payment forms, it's had a real big impact on people. Their ability to get from their property to engage in a group of any sort, whether it's [delivered] through Mind or Samaritans or the NHS, but some involvement in their local community is becoming more and more difficult. One, because access to those, because it's difficult to get to but also the lack of provision of them in the first place." (Clinician 6).

In a climate of austerity where the language of scroungers, skivers and shirkers paints those with visible or not so visible disabilities as non-contributors to society, when combined with reductions in funding to public services, results in a narrowing of the treatment options to the purely 'medical' and the urgent. One clinician (2) described it thus: "… we did treat quite holistically, we've now become a unipolar deliverer." This situation has been compounded by the centralisation of many of the remaining services in Shrewsbury:

> "… the social aspect is really important and actually that can be as beneficial as the medication and therapeutic interventions. … [Council] budgets have been cut year on year for many years now and the services have become centralised. So if you live in Shrewsbury or Telford you've got a better opportunity to access services than you have in rural areas." (Clinician 4).

Previous psychosocial interventions and support have been scaled back ("we've only got two support workers in the team so it's a bit difficult really" Clinician 5) in the area of sports and recreation, social interaction and re-acclimatisation after inpatient treatment as well as more broadly in education:

> "And it's not only what they can't get to, it's what they can't afford either. We used to have more money available and pockets of money that we could try and get to help someone who wanted to study and now that's not possible anymore. We don't even have petty cash to speak of. So, the cost of transport they probably couldn't afford on benefits, never mind the actual cost of the course itself." (Clinician 2).

Carers also complained that the Council-run support service for carers had also been subject to cuts resulting in a centralised and generic service for carers of all health conditions instead of a specialised service targeted to the needs of specifically mental health carers:

> "… we used to have support workers within the Community Council and previously we had very well qualified support workers who were experts in autism, mental health, and various things like that. They got made redundant when the Community

Council downsized or whatever, and then they've switched over to this Carers Trust 4all who just do a generic support." (Carer 4).

Many times the retrenchment of services and narrowing of treatment options results in the non-recording of these unmet social needs where clinicians know their provision is either unobtainable or other factors such as cost or transportation make them unfeasible:

"… unmet needs have to be explicit really and sometimes people aren't offered services because they're not there or people are told of what services could be there but aren't or they may find difficulty in accessing them too. So they don't actually go onto people's care plans as an unmet need and they really should do…" (Clinician 3).

Re-modelling of community services:

Austerity and the need to make yearly cost savings (through NHS initiatives like the Cost Improvement Programme) have led to various re-organisations of service delivery. Over the period this project was actively collecting data, the community mental health teams were "re-modelled." Previously, six locality-based teams covered all the adult mental health needs of the population in a defined geographic area – 2 teams covered the North and the South of Shrewsbury, the rural areas of Shropshire were covered by 4 teams based in Ludlow, Bridgnorth, Market Drayton and Oswestry. The re-organisation created new Pathway teams covering a much larger area but offering more specialised care and treatments (there are specialised teams for Psychosis, Community Intervention, Intensive Life Skills and Memory Service and Dementia). A central phone number and triage service routes new referrals and re-referrals to the appropriate team. One of the consequences for rural areas is that while the clinical teams cover a narrower set of conditions they cover a larger area, making the logistics of home visits more challenging.

Such a large-scale re-organisation has resulted in considerable disruption to established patterns of contact, methods of communication and changes to key personnel such as care co-ordinators. While it is difficult to disentangle the consequences of these changes from the challenges associated with rural service delivery, the re-organisation clearly has had impacts for service delivery that are still to be fully worked out:

"…we are seeing some brain drain really of quite a lot of the older and more experienced staff members who just don't want to put up with some of the changes really. They move, I see them move between different teams or move to different areas. So staff retention and probably that comes onto another point and that's the

morale of staff. I think that's universal though to social welfare, mental health services and probably a lot of the areas of the NHS at the moment, given the huge demand." (Clinician 3).

These pressures impact on the model of service delivery too: "But I think the money does run out, doesn't it, and it does limit what can be delivered." (Clinician 5). A less holistic approach results and this has a particularly exaggerated impact in rural areas:

> "…another problem we face and particularly in this area as it's a very rural area so lots of the models of care, lots of the delivery theories, the delivery standards that have come through the NHS management, could be argued to be perhaps more pertinent to suburban or city areas where you know to have staff travel around to see patients, to have administrative time between seeing patients and access to some of the IT support and infrastructure that allows for that is easy to apply maybe in a suburban or city area but in the rural area." (Clinician 3).

The re-organisation has impacted too on the relationship between primary and secondary care: "One thing we've lost with the recent restructuring is the very critical link with GP practices so we see and advise people perhaps in an earlier stage when they're suffering mental health problems" (Clinician 3). This is echoed from the primary care sector:

> "For patients with significant mental health issues, again access is a problem, in particular the changes that have been made with the mental health service where [the GP] can no longer can ring up a [nearby] clinician. We used to have a good, and we still have a good relationship with the clinician but we can no longer ring him. We used to be able to just ring him or pop down the road and say we're really worried about this patient, there's somebody that they've been seeing, can they advise? And usually he would fit them in." (Clinician 1).

While some of these issues may be temporary and only be a concern until professionals find ways of making it work in a new configuration of services with new lines of communication, but the issue of the physical infrastructure of service delivery remains (and not just in terms of transportation costs). A high profile building in a small, rurally-focused community for example can have significant implications for accessibility where fear of stigma and discrimination is associated with being seen coming to or from a mental health appointment:

> "I think the difference is that in rural areas where you have a service or counsellors that are in a specific building, everybody knows when you go in there and that's what

makes people reluctant to access it and because it's a small town it very quickly spreads…" (Clinician 1).

2.3 Delivering Mental Health Services across Rural Shropshire

Austerity has clearly had an impact across Shropshire mental health services and its rural nature appears to have led to an even more detrimental effect. As one clinician states, for mental health services "… it's the biggest challenge across the whole service because this is the biggest geographical patch" (Clinician 4). Clinicians contributing to this study spoke with a sense of loss when discussing the delivery of services. Whilst much appears to stem from the impact of 'Austerity' (see above) it is also tied to the inherent limitations and challenges of delivering mental health services within a rural area.

In the discussion about advantages and disadvantages of living in a rural area, service users identified access to and the lack of services as well as that "there's not much to do" (Service User 1) as the main disadvantages. There is no doubt amongst clinicians that recent changes are centralising services. They now must concern themselves with the infrastructure and acknowledge the difficulties that discharging or referring patients to other services can have:

> "In terms of people being discharged to services in more rural areas, there tends to be a little bit less in terms of that supporting infrastructure around… so there might be limited choices, there may be fewer places." (Clinician 7).

People come to rely on local support when mainstream mental health services are moved away from their community. However, within rural areas the services that can be relied upon in an urban area to 'fill the gap' are not available.

> "in areas where there are larger conurbations there is often a greater concentration of services and, crucially, there is often better infrastructure around in terms of not just those community mental health services but also accommodation, other voluntary sector projects who provide active support and fill the gaps." (Clinician7)

Even for service users, there is recognition that rural does not always mean that there is a community one can rely on:

> "I think there is a type of, just because it's a rural area doesn't mean to say that everybody does look out for everybody else." (Service User 4).

The lack of support from third sector groups in rural areas can put undue strain on the carer who is faced with services where they "… have seen quite a lot of change away from a sustaining level of support towards a recovery model of support" (Clinician 3) and when discharging people means that the system is "… reliant on the infrastructure around them in playing its part" (Clinician 7). Carer 5 sees it as "getting numbers through the system" and is faced with panic when the person she cares for is discharged "… because where do you go from there?" She felt that "you have nowhere to go… I just had to learn to deal with it myself".

There is confusion about what services are available, whether due to the changes in delivery or as a result of the rurality of the individuals; that means carers feel they have to become experts in their own right:

> "Once I was told, if it gets bad ring 999 (agreement from others) and when 999 got there, this isn't a 999 thing, what are you ringing us for?" (Carer 2).

Clinicians admit that as services are moved further away they are faced with successfully delivering services with far fewer resources and more limited awareness of what is available:

> "it's about resources and not quite having the right thing for your person that you're working with available at that time or knowing about it." (Clinician5).

The impact is concerning:

> "… given the nature of increased demand in service, increased public expectation of what can be provided, and a shortfall in staff members, of those staff there's more being asked of them in terms of administration… you can't really empower staff to be in a caring role when they themselves are close to burnout." (Clinician 3).

Travel time & cost:

The logistics of providing mental healthcare in rural areas can be "administratively time-consuming for professionals" (Clinician 3). Whilst "you lose an awful lot of time in travel" this needs to be balanced against the fact that "generally, when people are feeling unwell they want someone to come to see them" (Clinician 4). In many ways it makes no sense to provide mental healthcare in a rural area. It is not cost-effective "…in a small community when say five people might use it" (Clinician 2). Limited means of transportation means "… it's a struggle for them to get to us, for us to get to them and for them to get the proper services" (Clinician 8) even when they are being delivered close by.

Clearly, carers and service users must at times take on the burden brought about by a lack of resources. Mental health services come to rely more on the families and friends of service users but within rural or large geographical areas this can mean a disconnect between where services and families are. Service User 1 talks positively about where he currently lives, his home community with his mother, but a supported living facility far from his family was an unhappy place to live:

> "… they offered me a place in a rural village and I went there for about four months and I hated it. I wanted to get away from there and it took them about a year and a half to get me out of there." (Service User 1).

Clinician 7 recognises this when he addresses "the likelihood that accommodation and placements are either going to be in Shrewsbury or Telford and people's family and friends may be spread out quite widely or in more distant parts of what is quite a large geographic area… So making that support a realistic and an active part of people's treatment plans and care plans can be a challenge" (Clinician 7).

Often there is an additional burden for service users and their families in the form of more expensive and longer journeys. For carers this can lead to the perception that they are being discriminated against, not only due to the nature of mental health needs but also to the additional challenges of living in a rural area:

> "… if you're a mental health carer and the person you care for is taken to a hospital a long way from your home you can't claim for travel allowances. So mental health carers are discriminated against. Most carer's assessments ask whether you feed the person, whether they can go shopping on their own, whether they can dress themselves. That is not always really relevant to dealing with somebody with a serious mental health problem but it's not reflected in the assessments. So I would think all of the statutory bodies – whether they're support workers, assessors, whoever they are – none of them really understand mental health and that leaves you feeling more isolated and unsupported, especially when you've had good support before, and then you end up with people who say we don't know, we just support you generically." (Carer 4).

The expense and time of travelling to services, not just mental health but supportive or recreational activities can also hinder the empowerment of service users. These extra distances can be difficult for someone with mental health needs to manage:

> "… one can spend the whole day travelling to get there for half an hour and maybe it's just too much when someone is unwell to spend the whole day on public transport to go and play football." (Carer 3).

Whilst service users clearly enjoy the rural nature of where they live they also recognise the lack of public transport – "It was a nice place to live [but] no buses" (Service User 2). Clinicians also see this as a barrier, particularly the additional costs associated with making it to appointments:

> "your only other option is a taxi, isn't it, to get about, but they are expensive." (Clinician 5).

And,

> "It's the travel part and it's the cost of the travel that would be the main issue [with centralising services]." (Clinician 6).

The distance for those with mental health needs also impacts on their access of services, increasing the likelihood they will be unable to attend:

> "I've been in that situation a couple of times where I've had to ring up and cancel appointments because it's not safe. If she is really upset she will jump out the car and it's not safe." (Carer 2).

However, in discussing these issues with service users it became clear that whilst available activities were certainly limited they were still often able to find things to do:

> "I'm never short of things to do. I play football, I swim every day." (Service User 3).

The resilience of rural communities can support service delivery and providing mental healthcare locally in rural areas appears to be effective:

> "Central Shrewsbury has a high referral rate for us. Rural areas not so much but in the past the local community mental health teams dealt with everything within their area." (Clinician 9).

There is a certain resilience that came through strongly amongst the service users and carers. Carers talk about fighting for those who they care for, tackling services to ensure that they are provided with the treatment they need and becoming experts in mental health: "[services] do not recognise that carers are experts in that person" (Carer 2) and "carers have to be experts in the condition" (Carer 4). Service users discuss the many ways they support themselves in

their wellbeing. It's clear that people are happier when they have low-level supportive services close by. The service users discussed the many different hobbies, courses, and sports they were involved in as a positive part of their lives. These activities helped them to create a community of people they felt safe with, an alternative to mainstream mental health services – "… that's what the psychiatric hospital does for ya. You feel safe. Safe from the outside world. Blaggers, thieves, you know whatever, you know, addicts. You're away from them for a while." (Service User3).

However, carers also recognise that not all service users are fortunate enough to have someone close to them who can help them to access the services they need when they need them: "I know that I am a strong advocate for my daughter and I feel sorry to the bottom of my heart for all these poor people out there who've not got a mum or dad or brother or a sister to fight the battle for them." (Carer 2).

Local experience and local knowledge:

Local experience and local knowledge are important for rural provision of mental health services. Distances are elongated by the inevitable delays on small country lanes and this can lead to a knock-on effect within provision on any one day:

> "We had very serious problems because the carers were literally turning up hours late. The morning call would turn up, supposed to be there at half 8 and they'd be there at half twelve… The actual carers themselves were great. The problem was the organisation, being a rural route, they really hadn't factored in that you can't get to Oswestry from Craven Arms in ten minutes [agreement from group]. Say there are roadworks on the A49 you can't get from Craven Arms to Ludlow in ten minutes." (Carer 1). [The distances are 38 and 9 miles respectively].

This carer clearly bemoans the unfamiliarity of the organisation with 'local' experience. The clinicians who have spent a longer time in Shropshire also reflect the changes within provision that have meant community knowledge has been replaced by a more expert but generic service:

> "We've changed the way that we're focusing services so people get a more specialised intervention but they don't get a localised intervention." (Clinician6).

Carers have also recognised these changes:

> "we used to have support workers… we had very well qualified support workers who were experts… They got made redundant when the Community Council downsized or

whatever and then they've switched over this [other organisation] who just do a generic support." (Carer 4).

Changes to service delivery have also had an impact on how clinicians are able to provide for their patients with mental health needs and the support they have in doing this:

> "The IAPT people [Improving Access to Psychological Therapies] have taken over the [GP] surgery work that we were doing but the [GPs] really liked our service because we're trained not just in psychological therapies but in psychiatric work. So we could look in both sides of the fence and see which the person needed most appropriately and we also had a good understanding of medication, etc." (Clinician 2).

And:

> "We've gone to a centralised referral mechanism now for professionals like GPs where they've got local contacts with clinicians or where CPNs or other health professionals used to work inside GP surgeries. Patients had a greater accessibility at a lower level to access services and I think very often that had a preventative role,…" (Clinician 3).

The carers are frustrated by the lack of local knowledge that new providers of services have. Whilst they are "…used to things like being stuck behind tractors and farm machinery" (Carer 1) when the new provider took over delivering carer-services "… they could not get their heads around how somebody couldn't see somebody in Oswestry and half an hour later visit someone in Ludlow" (Carer 4).

This lack of local knowledge can mean that with restructuring and new providers delivering services the learning curve becomes more difficult as individual healthcare professionals have to quickly familiarise themselves with a complex and potentially disjointed support environment. They must become acquainted with a large geographical area with numerous small third sector facilities rather than in urban areas where provision is centralised and often involves larger single organisations:

> "I guess other areas are about the actual community and knowing what's out there in your community and things pop up and pop down all the time, don't they in terms of resources? And you rely on your networks in the team and having conversations and people saying 'oh I've heard about this' and, you know, that knowledge is really important to reduce the barriers really." (Clinician 5).

All the participants discussed their ideal service not necessarily as one that was always accessible but rather one that was available when and where it was needed. For instance, whilst it may be recovery-focused, both carers and service users felt there was a need for faster access to be possible in the case of relapse or need for more expert input:

> "…they said she was able to be fast tracked back in. But when I've contacted them about fast tracking her back in, [they say] 'no,' she needs to be re-referred." (Carer 2).

In a rural area the distances mean that at times there is a certain level of danger and urgency associated with a mental health crisis that cannot be addressed in the same way it can in an urban area. For instance, clinicians may feel that they are placed in a potentially more dangerous situation - "… lone working is an issue… if you are alone in the house of someone who gets the hump" (Clinician 9). Likewise, carers can feel that they are more vulnerable when local mental health services do not intervene:

> "…when the Community Mental Health Team (CMHT) say the service user doesn't want to engage, they can't make them, that actually leaves the carer very vulnerable and in a very dangerous position and they actively just walk away and leave that carer to deal with what could be a life-threatening situation and that is disgraceful. If that was any other organisation, including the police or anybody else, there would be an enquiry when anything further happened. But with the CMHT they simply switch something off or close the case and walk away. It's disgraceful." (Carer 4).

It appears to be the rural nature of their living situations that leads to this perception of being left vulnerable:

> "… we're out in the middle of a field and when she has a meltdown at two o'clock in the morning it's a very long time before anybody, even if they would come, can get there and it can be very scary because she can be prone to violence when she gets really, really upset." (Carer 2).

Clinicians recognise that within any area it can be necessary to prioritise if multiple crises are reported:

> "if… we get two calls and we can look at them side by side, we would respond to the one on the highest risk. We would travel to that person… the other person we would make contact and say we can be with you but not right now… so I think your example isn't just about people that are living in rural areas, it's whoever we don't get to see

first of all. Because that might be someone who lives in Shrewsbury or Oswestry." (Clinician 6).

That services are delivered based on priority rather than rurality is reassuring but the vulnerability that carers feel and the length of time that it does take services to arrive when a service user is in crisis should also be addressed:

> "I talked about having to wait for hours for an assessment to take place… I had to wait four hours… because one of the clinicians was in Oswestry and it was a foggy night… and it was pretty horrendous trying to control a young tall young man who was in a psychotic state." (Carer 3).

This suggests that whilst crisis teams may be responsive to priorities this does not always factor in the additional challenges presented by rural isolation.

2.4 Stigma and discrimination; passivity and acceptance

It has been suggested that for rurally-based service users a sorting process takes place based on the experience of living in different sized communities. For the service users attending our focus group, the experience of both very isolated, small communities as well as large cities proved to be negative and were subsequently avoided. Finding a comfortable place in the urban hierarchy was a learning process and ultimately influenced by a number of factors, including the availability of suitable housing, proximity of family and other support networks, historical knowledge of the community and so on. Certain attributes of the community were seen to be supportive for building a network of friends and acquaintances (a community broadly tolerant of difference and one with a sufficient scale of social infrastructure made up of friendly meeting places, community-run education and social groups and the like). These social resources were recognised to vary widely between places (and vary amongst places of a similar size). For people with a serious mental illness the size of the community can either hide or highlight the condition and has implications for service delivery in that location, as one clinician described:

> "… in a city area when you have an episode of illness and somebody might be very unwell and then maybe do something very erratic or become naked for instance, that often happens with people when they're elated, I think that they can go back to the city and they're more or less anonymous. In this kind of area everyone will know what you've done and people have to live with that shame. That's why they need support

> when they come back from hospital to face [it] out in the community, to have someone to walk around with until they feel that those feelings of shame have died down. Or if they've been shouting in the street and unwell, it's difficult to come back to." (Clinician 2).

The visibility of both service users in a community and services designed to support them, is a real and widely recognised issue both from a secondary and from a primary care a perspective:

> "… a lot of people won't come here because the Tesco café is over the road and everybody [here] knows everyone or is related." (Clinician 2), and:

> "I think there is more of a stigma because it's so visible [in rural areas] whereas in a bigger [place] people don't really care if you went into the blue door at the bottom of the street whereas here it's quite obvious where you're going." (Clinician 1).

Both carers and service users acknowledged the significance of stigma and associated discrimination: "the minute something happens everybody knows" (Carer 2) and service users cited examples based on personal experience:

> "I was in a rural village at the time. It was bonfire night nearly and I wanted to get some fireworks in the shop and she said 'I'm not serving you these'. I said I'm old enough. She said 'I'm not serving you these, I know where you live, you got mental health and I'm not serving you'… she knew where I lived and wouldn't serve me." (Service User 1).

And,

> "I was on the train once going down to see my dad and I got chatting to this woman, we were chatting away for like about an hour and a half, getting on really well and she asked… what do you do for a living? I said oh well I'm on disability and she said oh what's wrong with you and I said oh I'm schizophrenic and she went oh. Two minutes later she said I'm just going to the toilet… she had to walk past me to sit somewhere else!" (Service User 1).

Throughout the focus group participants exhibited a passive acceptance of their condition and life circumstance: "I'm happy with what I've got" and "I don't worry about it, if it happens it happens" (Service User 2); "life's too short to be full of regret" and "I'm comfortable as I am" (Service User 3). In response to the specific instances of discrimination described above their impact was down-played: "that's life, isn't it. It's nothing to worry about. Just a couple

of words" (Service User 1). Another service user appeared to embrace the identity imposed upon him; "some people call me a crazy but I am a bit wild. I'm OK with that" (Service User 3). As noted, in response to these experiences service users sought safe locations in rural areas small enough to avoid over-stimulation but large enough to be able to build a community of other service users: "Like I said, a lot of the time I'm with my mates watching videos, music videos, and having a chat and stuff." (Service User 3).

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3.1 Conclusions

Shropshire is a predominantly rural county with a large, central urban 'node,' Shrewsbury, which is also the county seat. Four market towns anchor the rural areas in each of the compass quarters (with Whitchurch in the far north not quite meeting the threshold for an urban area in the last decennial census). These 'hub' towns fall into the ONS category of "rural related" as they have populations of between 10 and 30 thousand and are orientated primarily towards serving their sparsely populated surrounding hinterlands. As a result, about three quarters of the total population of the county live in areas defined as 'largely rural' (a category comprising of 'rural' and 'rural related'). While some rural areas are relatively affluent, other parts of these same rural areas score highly in the index of multiple deprivation (where deprivation can be concentrated in small pockets and often hidden from public view). While overall rural populations have slightly better health (Nicholson, 2008; Weich *et. al.*, 2006), the prevalence of mental health conditions is slightly higher in rural towns and urban fringes (where this is associated with economic underdevelopment and lack of services).

Austerity has had and continues to have an impact across the county. The county's budget has seen dramatic reductions since the financial crisis (central funding for county councils is set to fall by 77% by 2020) and Shropshire County Council's budget remains firmly in deficit. In response, services have been cut and more cutbacks are planned (despite the 'end of austerity' recently heralded by the government). This has impacted on the lives of the county's residents in a variety of ways and, given the tendency to centralise services in urban areas, it is likely that a differential burden has been borne by rural residents. This is perhaps most apparent in cutbacks to subsidies to public transportation. These have resulted in a reduction of bus miles of over 20% leaving some rural areas without any regular bus service. The tendency to centralise other services in Shrewsbury has further exacerbated limitations to accessibility by particularly rural residents and this further impacts on people without access to cars (Titheridge, *et. al*., 2014: 12).

Austerity has impacted service provision and delivery while simultaneously impacted on the welfare of individuals – those on low incomes via changes to tax credits and reductions in benefits, unemployed people and those needing support for medical reasons. Welfare payments have been reduced and new regular medical assessments introduced. The transition to Universal Credit has been slow, problematic and created hardship as new payments are delayed so as to mimic salary payments paid in arrears (leading to a lag for some of five

weeks or more in receipt of payment). A former senior civil servant who headed the Independent Parliamentary Standards Authority and who is currently terminally ill with cancer and suffering with Parkinson's disease, described his own experience with the benefits system as being a "hostile environment":

> "A former top civil servant has criticised the disability benefits assessment system as a "hostile environment" after being told he was ineligible for support despite having Parkinson's and terminal prostate cancer. [He] described the assessment process… as crude, unprofessional and Kafkaesque in its complexity."[11]

If highly educated professionals experience the welfare system as hostile and inaccessible it is easy to see how much more difficult and intimidating it is for people with a mental health condition. In fact, a recent report by academics from Newcastle concluded: "Managing the UC claims process and increased conditionality, combined with the threat of sanctions, exacerbated long term health conditions and impacted so negatively on participant's mental health that some had considered suicide" (Cheetham, *et. al*., 2018). This adds to a growing body of evidence from early independent evaluations of the changes to the welfare system commissioned by the DWP (Harrington, 2010; Harrington, 2012 on the privately contracted medical assessment process) as well as National Audit Office audits of the system (NAO, 2018) and findings of the House of Commons Work and Pensions Committee.[12] Surveying the evidence, Stuckler *et.al.,* (2017: 19) conclude: "…the available evidence indicates that austerity has exacerbated and prolonged the mental health risks associated with economic downturns."

For rurally-based Shropshire mental health patients the impact of austerity has been multiform:

- Reductions in PIP payments have reduced levels of independence by restricting mobility. The majority of mental health service users participating in this study did not own a car (either because of a withdrawal of a driving licence or due to the

[11]*Guardian* (06/10/2018) "Former watchdog chief labels disabled benefits process a 'hostile environment.'" Available from: https://www.theguardian.com/society/2018/oct/06/former-watchdog-chief-labels-disabled-benefits-process-a-hostile-environment

[12]Numerous reports are available on the committee's webpage looking at all aspects of the Welfare system many of which highlight the negative experiences of people mental health conditions: https://www.parliament.uk/business/committees/committees-a-z/commons-select/work-and-pensions-committee/publications/

expense of buying and running a vehicle) and were therefore increasingly reliant on public transport which itself has diminished in coverage and frequency.

- There has been a direct impact on carers through a reduction of support services for carers. A county-wide support service with specialist support for mental health carers was replaced with a new generic service which the carers were much less satisfied with. Carers felt that this decline in support coincided with greater responsibility for managing the care of a loved one, particularly during times of crisis. Service reduction and service re-organisation have also disrupted the pathways back into services after periods of relative good mental health.
- Community mental health services now offer a more restricted service (this was described by clinicians as a 'unipolar' service and 'delivering a crisis service now rather than recovery [service]'). A more holistic approach which recognised the psycho-social needs of mental health patients has contracted to focus narrowly on the 'medical' approach of managing symptoms primarily through medication and a quicker discharge to primary care.
- While austerity has helped to shrink the social universe of service users there has been a concomitant rise in unmet needs – to the point where these unmet needs are not even being recorded in patients' records (this is a problem across the NHS, as recognised by NHS Improvement, 2017: 5). Activities such as 'Walk and Talk' groups, informal 5-a-side soccer games and the like are either no longer supported or take place in central locations such as Shrewsbury and are consequently harder to access by either rurally-based service users or their carers.

While it is difficult to disentangle the impacts of austerity from the related and compounding factors such as changes to service provision, service delivery, new technologies of healthcare delivery and changing demographics (like the aging population of Shropshire), there is little doubt that rural residents of Shropshire have been impacted particularly hard and mental health patients and their carers are subject to an extra burden imposed by the geography of the county. As one clinician noted: "I think that the geography of Shropshire is a challenge which we're not going to be able to rectify because we can't move places" (Clinician 10).

Although our service user sample is small and all similarly middle-aged, they had engaged in an implicit process of 'geographic exploration' across the rural-urban hierarchy eventually discovering a settlement size which met their needs for social interaction, volunteering and

other activities, and which was simultaneously close to family and other support networks. These tended to be the hub market towns or slightly smaller communities. Very small communities in remote locations with sparse populations were universally agreed to be undesirable: "it was the middle of nowhere,… there was no-one about except for cows and sheep." Further research is required to investigate how widespread this pattern is nationally as it has implications for where health and social care resources could be best concentrated for greatest impact in the context of increasingly centralised service delivery.

While little can be done to rearrange the geography of the county of Shropshire, we nevertheless draw out a number of recommendations from this study; these are presented below.

3.2 Recommendations

- *Participants in this study expressed a desire for support for their mental health conditions to be provided locally, routinely and at a low level. This is consistent with findings from elsewhere in the country. We recognise that cost pressures make this difficult for such a rural county. However, care needs to be taken when centralising services as this has the potential to disenfranchise rural mental health service users and their carers.*
- *A rural county such as Shropshire must provide not only for its urban service users but also for those individuals who choose to live rurally. As resources become more centralised commissioners must recognise what is needed to maintain an infrastructure that supports individuals seeking help. Drop-ins or groups that enable them to feel supported within their community may offer some a sense of belonging, but efforts must be made to minimise the fear of stigma that can comes from their use.*
- *An alternative may be to offer more generic courses and training service users and carers, free from mental health terms, but with instructors trained in mental health first aid. This would also require local clinicians be kept up to date with what is available in their community and centralised clinicians, including care co-ordinators, to be aware of what is available in the individual's locality. It is recommended that the existing resources, such as the Shropshire Community Directory, are better utilised both by Shropshire Council and CCG to ensure that it is kept up to date and can offer clinicians and carers a central database of local activities for service users.*

- *Transport for those with mental health needs in rural areas can be particularly challenging as there is often multiple connections needed. We recommended that rural transport schemes are explored – these are often provided for elderly residents but the feasibility of their use for service users and their carers is advised.*
- *Service users and carers had chosen to live in rural areas for the most part but supported accommodation in Shropshire is not always available in urban areas. If individuals are moved to smaller villages it is necessary to recognise what additional needs they might have, particularly when considering potential discrimination from the community due to the visibility of their living situation. Strategies to encourage integration are needed to help acclimatise service users and normalise their experiences within the community. For instance, schemes such as community gardens can offer ways of working together for a common goal.*
- *Digital resources can offer service users and carers, as well as clinicians in rural areas the chance to access therapeutic interventions, information and support in a cost-effective way as they are not limited by geography. However, most will require hardware (e.g. smartphones), sufficient internet connectivity and guidance. Computerised cognitive behavioural therapy is NICE approved and effective in the treatment of depression and anxiety but still under-utilised. Successful implementation in rural areas relies on the involvement of clinicians in educating and supporting service users in its use. It is recommended that clinicians collaborate with local internet cafes and libraries to empower service users in utilising digital resources successfully for information seeking and self-care.*
- *Service users benefit from volunteering and the skills they learn help to contribute to their community. However, employment opportunities do not appear to be personalised to their needs; rather they are offered generic placement at organisations that may not be supported in employing people with additional requirements. Helping local businesses to understand how they can successfully employ mental health services users is essential and opportunities need to be tailored to the skills and needs of the individual. It is recommended that the DWP liaise with local businesses and deliver programmes to encourage involvement of individuals with mental health needs. Volunteering and skills training should be included as a component of care rather than as part of the benefit system to encourage and empower service users in helping their community.*

- *Clinicians should record unmet needs in mental health patient's care plans in order to evidence the extent to which these important psychosocial needs are no longer being met.*
- *Services should ensure that carers are involved as they can offer important insights into the service user's needs. Predictive or proactive strategies are needed to ensure that they do not feel vulnerable and that potential crises are identified so that service users can access support and services when they are needed.*
- *Third sector and voluntary organisations provide an often invisible but essential service within the health economy. However, their reach is restricted within rural areas due to funding and population concerns. It is recommended local services that provide support, information, advocacy and training for all areas of the community are encouraged through recognition of their role and better funding opportunities. Other areas have appointed co-ordinators who work to match local needs with small and medium enterprises who can offer solutions, providing support in writing bids and helping to engage the community.*
- *Rural proofing of services. Rural proofing of public policy has been developed to account for the differences in needs and costs associated with rural areas. We recommend this exercise be applied to the restructuring of service delivery during the planning stages of these changes so the implications for rural areas can be anticipated and ameliorated.*

3.3 References

Bibby, P. & Brindley, P., (2013) *The 2011 Rural-Urban Classification For Small Area Geographies: A User Guide and Frequently Asked Questions (v1.0),* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/239478/RUC11user_guide_28_Aug.pdf.

Braun, V. & Clarke, V., (2006) "Using thematic analysis in psychology." *Qualitative Research in Psychology*, 3(2), pp.77–101.

Cheetham, M., Moffatt, S. & Addison, M., (2018) *"It's hitting people that can least afford it the hardest" the impact of the roll out of Universal Credit in two North East England localities: a qualitative study*. 47pp. Available at: https://www.gateshead.gov.uk/media/10665/The-impact-of-the-roll-out-of-Universal-Credit-in-two-North-East-England-localities-a-qualitative-study-November-2018/pdf/Universal_Credit_Report_2018pdf.pdf.

DCLG, (2001) *Urban and rural area definitions : a user guide*. Available at: http://www.communities.gov.uk/documents/planningandbuilding/pdf/156303.pdf.

DEFRA, (2011) *Inequalities in health outcomes in rural areas*. Available at: randd.defra.gov.uk/Document.aspx?Document=Healthinequalities-Finalreport.pdf.

Donaghy, J. (2012) "Breaking the Silence in Rural Areas'Rural mental health, stigma, services and supports within the SWARD Region.' Report published by the Níamh Louise Foundation, available from: http://www.niamhlouisefoundation.com/wp-content/uploads/2010/12/the_niamh_louise_foundation_breaking_the_silence_in_rural_areas_research_2012__sward___1_.pdf

Gregorie, A. & Thornicroft, G., (1998) "Rural mental health." *Psychiatic Bulletin*, 22, pp.273–277.

Harrington, M., (2012) *An Independent Review of the Work Capability Assesment*, Available at: https://www.gov.uk/government/uploads/system/uploads/.../wca-review-2012.pdf.

----- (2010) *An Independent Review of the Work Capability Assesment -year five*, Available at: https://assets.publishing.service.gov.uk/government/uploads/.../wca-review-2010.pdf.

Kirkbride, J.B. *et. al*., (2014) "Social deprivation, inequality, and the neighborhood-level incidence of psychotic syndromes in East London." *Schizophrenia Bulletin*, 40(1), pp.169–180.

Kvig, E.I. *et. al.*, (2017). Geographical accessibility and duration of untreated psychosis : distance as a determinant of treatment delay. *BMC Psychiatry*, 17:176 . pp.1–10. DOI 10.1186/s12888-017-1345-8.

Lederbogen, F. *et. al*., (2011) "City living and urban upbringing affect neural social stress processing in humans." *Nature*, 474, pp.498–501. (23 June 2011). DOI:10.1038/nature10190

Local Government Association, (2017) *Health and wellbeing in rural areas*. 47pp. Available at: https://www.local.gov.uk/sites/default/files/documents/1.39_Health in rural areas_WEB.pdf

Mental Health Foundation, (2017) *Mental Health in Wales: fundamental facts 2016*, Available from: https://www.mentalhealth.org.uk/sites/default/files/FF16 Wales.pdf.

NAO, (2018) *Rolling out Universal Credit.* (June). Available from: https://www.nao.org.uk/wp-content/uploads/2018/06/Rolling-out-Universal-Credit.pdf.

Nicholson, L.A. (2008) "Rural Mental Health." *Advances in Psychiatric treatment*, 14, pp.302–11. DOI: 10.1192/apt.bp.107.005009

NHS Improvement, (2017) *NHS operational productivity: unwarranted variations Mental health services and community health services Summary document*. Available from: https://improvement.nhs.uk/documents/2819/20180524_Summary_document_-_NHS_operational_productivity_-_Unwarranted_v....pdf

Patient and Client Council, (2011) *Rural Voices Matter*, Available at: https://www.patientclientcouncil.hscni.net/uploads/research/Rural_Voices_Matter_-_June_2011.pdf.

Philo, C., Parr, H. & Burns, N., (2003a) "Rural madness: A geographical reading and critique of the rural mental health literature." *Journal of Rural Studies*, 19(3), pp.259–281.

-----, ----- & ----- (2003b) *Social Geographies of Rural Mental Health: Summary Report. Project Report.* (ESRC Funded Research Project, Award No.R000 23 8453). Available from: http://theses.gla.ac.uk/96751/

Polaha, J. *et. al*., (2015.) "The perceived stigma of mental health services among rural parents of children with psychosocial concerns." *Journal of Pediatric Psychology*, 40(10), pp.1095–1104.

Public Health England, (2018) *Shropshire Unitary Authority Health Profile 2018.* Available at: javascript:areaSearchResults.exportPdf('E09000020',102).

Rural England, (2017) *State of Rural Services 2016*. Available from: https://ruralengland.org/the-state-of-rural-services-2016-report/.

Shropshire, Telford & Wrekin, (2016) *Sustainability and Transformation Plan: Shropshire, Telford & Wrekin*, Available from: http://www.shropshireccg.nhs.uk/media/1259/shropshire-and-telford-stp-plan.pdf.

Skerratt, Sarah; Meador, E. & Spencer, M., (2017) *National Rural Mental Health Survey Scotland : Report of Key Findings*. (April). Available at: https://www.sruc.ac.uk/downloads/file/3332/national_rural_mental_health_survey_scotland_report_of_key_findings

Stuckler, D. *et. al*., (2017) "Austerity and health: The impact in the UK and Europe." *European Journal of Public Health*, 27(November), pp.18–21.

Titheridge, H. *et. al*., (2014) *Transport and poverty: a review of the evidence*. (July), 54pp. Available from: https://www.ucl.ac.uk/transport-institute/pdfs/transport-poverty.

Vassos, E. *et. al*., (2012) "Meta-analysis of the association of urbanicity with schizophrenia." *Schizophrenia Bulletin*, 38(6), pp. 1118–1123. doi:10.1093/schbul/sbs096

Weich, S., Twigg, L. & Lewis, G., (2006) “Rural/non-rural differences in rates of common mental disorders in Britain: prospective multilevel cohort study.” *The British journal of psychiatry : the journal of mental science*, 188(1), pp.51–57. Available at: http://bjp.rcpsych.org/content/188/1/51 [Accessed January 30, 2017].

Welsh Assembly, (2009) *Rural Health Planning – improving service delivery across Wales*. Available from: http://www.wales.nhs.uk/sitesplus/documents/829/rural%20health%20consultation.pdf

Welsh Government, (2012) *Together for Mental Health A Strategy for Mental Health and Wellbeing in Wales. Executive Summary and full report*. Available from: https://gov.wales/docs/dhss/publications/121031tmhfinalen.pdf.

Response from Midland Partnership Foundation Trust, the current provider of mental health services in Shropshire (April 2019):

This a useful paper that provides information on rural complexity and it is encouraging to see the focus on rural mental health. However, it is concerning that some of the conclusions may have been affected by some changes of team structure (and at a point in time): Staff providing community services for adult mental health were structured into community teams providing care along pathways for the care of psychosis, mood-related conditions, dementia, and with a specialist pathway to provide intensive lifeskills to those patients suffering emotional and well-being issues linked to personality disorder. These changes started from the beginning of April 2017 and continued over about six months when the new teams were formed. At the same time, a single access point was formed to support easier referral of new people to the services. We wonder whether the research was conducted during the period of change or at the early stages of operation of the new teams. One of the conclusions of the report states: Community mental health services now offer a more restricted service (this was described by clinicians as a 'unipolar' service and 'delivering a crisis service now rather than recovery [service]'). A more holistic approach which recognised the psycho-social needs of mental health patients has contracted to focus narrowly on the 'medical' approach of managing symptoms primarily through medication and a quicker discharge to primary care.

These are some current quotes from staff in response to this conclusion, which may update on current thinking:

"Staff were zoned into geographical areas to ensure that we reduced any unnecessary travel when we developed the new teams, and to ensure equity of provision depending on the population needs… I genuinely believe that we have greatly improved the quality of care that we provide as a result of pathways, enhancing holistic care, clients wellbeing, employment support through enable, physical health monitoring, psychological input, promoting recovery based care at the essence of everything we do." Psychosis West Shropshire team

"We offer up to a 3 year service and offer a number of family, physical, psychological and social interventions during this time, in addition to pharmaceutical interventions to support someone's recovery" Early Intervention Service

"This conclusion doesn't really represent the efforts made by pathways to provide equity of resources over the rural patch. For example, the increase in psychology for people with psychosis across the whole of Shropshire including seeing people in their own homes." Psychology

" What we are not I guess is a long term, low level generic service (any more) but rather one that has become more specialised and evidence based in its overall approach to M/H care." Community Mental Health