

Rural men's mental health

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INTRODUCTION

The importance of paying attention to both community context and social capital in relation to men's mental health has been highlighted elsewhere in this book (*see* Chapters 4 and 5). Nowhere is this more apparent than when considering the mental health of men in rural settings. This chapter starts by providing some general background to the rural context in the UK before progressing to consider what we currently know about rural mental health and specifically that of rural men. We then move on to look at how the issue of 'rural masculinities' might impact on rural men's mental well-being.

BACKGROUND

In the UK, one-fifth of the population live in rural areas – though definitions of what counts as 'rural' have until recently often remained unclear, with measures such as population density, complex indices and arbitrary judgement all being used at various times and in different ways (Gregoire and Thornicroft 1998). Hill's (2003) report on rural data and rural statistics pointed to the strong contrast between the statistical provision for agriculture as an economic activity and user of resources, and rural policy. He suggested that the inadequacy of rural data to service scientific enquiry and inform policy had been a longstanding concern and that an agri-centric view of the rural world in statistics was demonstrably inadequate and potentially misleading. This is because, whilst agriculture and forestry remain predominant users of rural land and the agricultural landscape remains an important feature of many rural areas, the proportion of people living in the countryside who work in these sectors is now only 2% of the population in England and 3% in Wales. The statistical provision for rural policy as a result has until recently been weak and fragmented because statistics which separate the rural from the non-rural are not available.

In 2004, the Department for Environment, Food and Rural Affairs (Defra) and the Countryside Agency began to introduce some clarity with the publication of new definitions for 'rural' and 'urban'. The new rural definition differed from its predecessors by focussing exclusively on land use, derived in such a way as to identify patterns of rural settlement (i.e. small rural towns, villages, hamlets and scattered dwellings) and was developed for use by funders, policy-makers and the Office for National Statistics. Defra admits that defining an area as either rural or urban may conflict with the 'look' or 'feel' of that area from the perspectives of local people (Countryside Agency *et al.* 2004). The new definitions were also developed to encompass the diversity of rural England and Wales in the 21st century, e.g. 'honey pot villages' that depend heavily on tourism, urban fringe commuter villages and former coal mining communities, and be applied to help target policy to those groups, communities and businesses that most required support.

RURILITY, HEALTH AND WELL-BEING

In general, rural communities enjoy better health and well-being than their urban counterparts. On standard measures of health (such as life expectancy and infant mortality) rural communities consistently score better. Evidence suggests that levels of the most common mental health problems are lower in rural areas (Weich *et al.* 2006). Generally, rural residents make less use of health services and have a more positive view of the state of their own health (Commission for Rural Communities 2005).

Urban and rural communities agree on the main factors that make the countryside a healthier and more pleasant place to live – peace and quiet, the predominantly natural or agricultural environment, lower crime rates and close-knit communities. These perceptions are reflected in the fact that more people living in rural areas wish to stay in their community for the long-term compared to people living in urban areas. Moving from towns and cities to the countryside is a growing trend in England and Wales (Commission for Rural Communities 2005).

Unfortunately, the widely recognised benefits of life in the countryside have led to the concept of the 'rural idyll' – an idealised stereotype of country life that ignores the real difficulties faced by many rural communities. Such difficulties include poverty, lack of services, poor public transport and traumatic social or economic change at a local level.

THE IMPACT OF POVERTY

Poverty is a reality across rural UK, especially in the most remote areas. The proportion of men and women in rural areas who earn low wages is greater than in the rest of the UK population and one in three individuals in rural Britain experienced at least one period of poverty during 1991–1996 (Shucksmith 2003). Furthermore, there have been big shifts in farming income in the UK – a steady decline since the 1960s reached a low point in 2000, with average Net Farm Income for all types of farm at just £8700, before rising to £38 600 by 2007/8. Farming incomes have been

particularly affected by specific crises (such as foot-and-mouth and BSE) as well as more usual problems, such as falls in wheat prices and poor harvests (Gregoire 2002).

Those living on low incomes, however, may be dispersed over large, sparsely populated districts. They are often as geographically near to more affluent members of the community as they are to others on low incomes. This means that their poverty is less visible to community planners and policy-makers, who use 'indicators of deprivation' that are more suited to the higher concentrations of poverty found in towns and cities. This 'hidden' poverty has a major impact on the health of individuals and families. People who are more vulnerable to mental distress are also less likely to enjoy the same level of health and well-being as the rest of the population.

MENTAL HEALTH IN RURAL AREAS – THE ISSUES

There are difficulties with access to services, low levels of health and social care service provision, isolation, higher product costs (for food, clothes etc) and lack of choice or quality of these products, all of which contribute to health and social care problems (Craig and Manthorpe 2000). Although rural England and Wales have social, economic and cultural differences, they do share some issues that are likely to affect the mental health of both their populations.

Provision of care and support services

Economies of scale mean that most services are located in urban areas, which are more highly populated. This is especially true of specialist services, such as care and support services for people with mental health problems.

Not only are there fewer specialist services in rural areas, but those that exist are likely to be many miles from a patient's home (British Medical Association Board of Science 2005). This has a serious effect on access to services in urgent or crisis situations, the availability of outreach services for those who cannot leave their homes and response times for on-call doctors who serve large, sparsely populated areas. The right of all NHS patients to choose between service providers (Department of Health 2004) means little if there is only one specialist provider across a large geographical area.

The time, money and effort required to travel to specialist services can impede the recovery and good management of mental health problems.

Access to transport

The quality of available transport is a major factor in whether urban-based care and support services are accessible to people who live in rural areas. People in rural areas usually find that public transport does not meet their daily mobility needs. Only 50% of the rural population have an hourly bus service within ten minutes walk from their home (Commission for Rural Communities 2005). The frequency, reliability and timing of rural public transport can make travelling to mental health services difficult or impossible. In many cases, a day return journey from home to a service outlet cannot be made using public transport (Swindlehurst 2005).

Due to inadequate public transport, most people living in rural areas find that owning a car is essential to their daily life. Frequently, people who are already in financial hardship get further into poverty from the costs of buying, insuring and maintaining a vehicle. People in rural areas who do not own cars are often reliant on private or voluntary arrangements such as taxis or lifts from family members and neighbours. However, these arrangements can be expensive or dependent on the willingness and ability of a small number of volunteers. The Institute of Rural Health has found examples of taxi fares (between £40 and £70 for a round trip) preventing patients in rural areas from accessing mental health services (Swindlehurst 2005).

Those who suffer from a lack of access to transport are often those most in need of accessing services. In some localities the NHS services provide a transport service to patients and elsewhere voluntary 'social car' transport schemes may operate. The availability of voluntary transport schemes will vary from one community to the next, with the Rural Community Council (England),* a branch of the Community Transport Association,† the Council for Voluntary Action,‡ the Women's Royal Voluntary Service§ or the British Red Cross¶ being good sources of local information about what might be available in a particular locality.

Access to information

Access to reliable, high quality information has a profound effect on mental health and well-being. It enables people to make the most of their lives, fully aware of their rights and the resources available to them. This applies to local and national community information in general, as well as to information specifically about health.

In rural areas it may be more difficult to obtain information about mental health issues locally due to a lack of infrastructure. Often shops, post offices, libraries and GP surgeries are widely dispersed or run services that do not meet an individual's needs (for example, shop opening hours may clash with an individual's working hours).

Some information services do have coverage of the countryside. The Post Office was until recently required by central Government to maintain its rural network.

* Rural Community Councils: the Rural Community Action Network is the collective name for the 38 Rural Community Councils throughout England, their eight regional bodies and their national umbrella, ACRE. RCCs are charitable local development agencies, generally based at county level, which support and enable initiatives in rural communities. www.acre.org.uk

† Community Transport Association: the CTA supports a wide range of organisations delivering innovative and flexible transport solutions to achieve social change in their communities. www.cta.org.uk

‡ Councils for Voluntary Action: NAVCA is the national voice of local third sector infrastructure in England. www.navca.org.uk See also Wales Council for Voluntary Action (www.wcva.org.uk) Scottish Council for Voluntary Action (www.scvo.org.uk) and Northern Ireland Council for Voluntary Action (www.nicva.org)

§ Women's Royal Voluntary Services: an age-positive charity that offers a range of practical services to help and support older people to live well, maintain their independence and play a part in their local community. www.wrvs.org.uk

¶ British Red Cross: a volunteer-led humanitarian organisation that helps people in crisis, wherever and wherever they are. www.redcross.org.uk

However, despite recent closures in its rural network the Post Office still has an important presence in some rural communities. All public library services have mobile facilities for remote parts of their catchment areas and organise visits to housebound library users. Citizens Advice,* through its network of local bureaux, may have a small outlet in a rural area, often in a small market town which is linked to a main bureau in a nearby urban centre.

Although the coverage of information outlets is inadequate, especially in rural areas, most organisations now use a range of media (print resources, telephone, email and internet) to communicate. Mind runs its Infoline† through both telephone and email and maintains a comprehensive website that is updated daily. Other national organisations involved in health and well-being, such as the Samaritans‡ and Age Concern,§ also provide information by telephone, email and internet. These methods reduce the need for 'physical' information outlets but do not replace them.

The barriers to accessing information faced by many people with physical disabilities can be greater in rural areas. Travelling long distances to information outlets can be difficult or impossible. Where small, local outlets do exist, they may be less likely to have had the 'reasonable adjustments' made that are laid down by the Disability Discrimination Acts (1995 and 2005) to make buildings accessible to disabled people.

People who do not have English as their first language may find it more difficult to find information on mental health in their 'mother tongue' in rural areas. Information on mental health in a range of languages can be accessed through Mindinfoline, which offers the Language Line service. Language Line is an organisation that provides interpretation services for non-English speakers and plays a 'third party' role between caller and a member of the Mindinfoline staff. Mental health information booklets in a range of languages are also available from Mind.¶ The Welsh-based information and advice service Community Advice and Listening Line** provides web-based and telephone services in English and Welsh.

WHAT DO WE KNOW ABOUT RURAL MENTAL HEALTH?

Given this background, these difficulties and concerns with major aspects of life in rural settings, what do we know about the impact this has on the mental health of those in rural communities and specifically on men in those communities?

* The Citizens Advice service helps people resolve their legal, money and other problems by providing free, independent and confidential advice, through a network of local bureaux. www.citizensadvice.org.uk

† Mindinfoline is Mind's mental health information service. www.mind.org.uk

‡ Samaritans provides confidential non-judgemental emotional support, 24 hours a day for people who are experiencing feelings of distress or despair, including those which could lead to suicide. www.samaritans.org

§ Age Concern/Help the Aged: the four national Age Concerns in the UK have joined together with Help the Aged to improve the lives of older people. www.ageconcern.org.uk

¶ Mind Publications: www.mind.org.uk

** CALL is the mental health helpline for Wales. www.callhelpline.org.uk

Despite the apparent stresses that such difficulties might suggest, there is evidence of lower rates of depression, anxiety disorder, panic, alcohol and drug dependency, and psychosis (Meltzer *et al.* 1995; Paykel *et al.* 2000) and schizophrenia (McCreadie *et al.* 1997) among rural populations in the UK. Yet such work may not present a full picture. For example, the reasons for apparently lower rates of various mental health diagnoses could be due to reticence to recognise or label symptoms as those relating to 'mental health' conditions – by both the rural population themselves and the health professionals that serve them. In turn, this has been suggested to be linked to a greater sensitivity to the stigma of mental health and to greater concerns about confidentiality in small rural communities (Sherlock 1994; Loblely *et al.* 2004). These issues of stigma and confidentiality may be of particular concern for rural men through links to notions of 'rural masculinity' and related stoicism and we shall look at this further shortly. For example, one study showed that despite a lower prevalence of psychiatric morbidity than the general population in Britain, male farmers were more likely to report thinking that 'life is not worth living'. The conclusion being that the relation between depression and suicidal thoughts appears different amongst male farmers than in the general population (Thomas *et al.* 2003).

These apparently lower rates of mental health problems may also partly be attributable to 'resource drift' where service accessibility is easier in urban locations. For example, in one study it was found that there was less specialist psychiatric (and more GP) treatment, lower psychotropic drug use and administration and later presentation for mental health symptoms in rural settings (Gregoire and Thornicroft 1998; Gregoire 2002). Therefore, as others have previously identified, such figures around lower rates of mental health need to be treated with caution as there may be evidence of greater hidden morbidity and higher thresholds for reporting symptoms in rural areas (Gregoire and Thornicroft 1998).

Men and young men feature significantly amongst those high risk groups which are particularly vulnerable to developing a mental health problem. For farmers, the difficulties and concerns associated with rural poverty outlined earlier cause stress through particular processes, with farmers showing higher levels of stress than the general population (Booth and Lloyd 1999). Farmers' stress has been shown to be related to new legislation and associated paperwork, financial pressures, media criticism and isolation (Booth and Lloyd 1999; Raine 1999). These issues have been compounded in the last decade by the outbreak of BSE and foot-and-mouth (Raine 1999) with a postal survey study showing farmers in affected rural areas having significantly higher levels of psychological morbidity than those in unaffected rural areas (Peck *et al.* 2002).

This being the case, it is no surprise that rates of suicide are of particular concern, with farmers being one of the professional groups at highest risk, accounting for 1% of all suicides in England and Wales (Booth *et al.* 2000). Likewise, in Scotland, 307 male farmers and farm workers died by suicide or undetermined cause between 1981 and 1999 (Stark *et al.* 2006). Factors associated with suicide in farmers are similar to those that cause stress outlined above. They include not having a confidant, work,

finance, legal problems, physical health and relationships. However, the most common single factor is the presence of mental health problems (mainly depression) which is found in 82% of farmer suicides (Hawton *et al.* 1998). Interestingly, male farmers who commit suicide are no more or less likely than men who committed suicide in the general population to have consulted a GP or mental health practitioner in the three months before their death. However, farmers are more likely to have presented with exclusively physical symptoms, suggesting differences in help-seeking behaviours. They are also significantly less likely to have left a suicide note and more likely to use violent methods, particularly firearms, in committing suicide (Booth *et al.* 2000; Stark *et al.* 2006). There is also some evidence that farmers have experienced mental health problems as a result of exposure to organophosphate chemicals found in sheep dip and other products that farmers use in their work (Health and Safety Executive 2000; Myhill 2003).

One positive outcome of the BSE and foot-and-mouth crises, however, is that public attention has been drawn to the experiences of affected communities, including the impact of these experiences on farmers' mental health. In addition, farming communities have generated self-help and mutual-aid organisations to support people in crisis. The Farm Crisis Network* recruits volunteers from the farming community (farmers, people from farming families, agricultural chaplains) who understand the practical difficulties that farmers face. Volunteers offer technical and pastoral support and respond quickly and confidentially to requests for help. They suggest the use of other services where necessary and provide support while farmers resolve their own problems. Many counties now have Farm Crisis Network support groups. Other national organisations involved in health, well-being or personal finance have gained a deeper understanding of the issues facing farmers over recent years.

Currently, and for the foreseeable future, farmers face the stresses of conforming to UK and European legislation, including complex bureaucratic procedures and financial uncertainty. Farmers who develop mental health problems rarely approach mental health services due to the stigma attached to mental health problems and the shame of being seen as 'not coping'. Due to their geographical location, farmers are often at a distance from mental health services, which makes them difficult to reach. In addition, farmers work long hours and may not be able to take time off during 'office hours' to use mental health services.

SUICIDE IN RURAL SETTINGS

It is not only farmers that commit suicide in rural settings. There is evidence that since the 1960s suicide rates in rural areas, in both men and women, have risen disproportionately compared to overall rates for England and Wales (Hill *et al.* 2005) leading some to suggest that the mental health of young adults, which influences

* Farm Crisis Network provides pastoral and practical support to farming people during periods of anxiety, stress and problems relating to both the farm household and the farm business. www.farmcrisisnetwork.org.uk.

suicide risk, may have deteriorated more in rural than urban areas in recent years (Middleton *et al.* 2003). Despite this rise in both men and women, rurality has a bigger impact on men's suicide than women's and the greatest risk of male suicide is in remote rural locations (Levin and Leyland 2005).

MINORITY GROUPS

Black and minority ethnic (BME) populations and lesbian, gay and bisexual and transgender (LGBT) populations make up minorities in many parts of the UK. They make up even smaller minorities in the countryside. Negative attitudes towards BME and LGBT people, reported across rural England and Wales (Hastings 2004), are not tackled effectively, mainly because the groups affected are so small that they cannot easily build strong local support networks.

Often, those who plan services believe that members of BME or LGBT populations do not live in rural areas (Mind 2003). This is not the case. As these populations tend to be small and isolated, individuals can suffer doubly from being visible within their local community but invisible to those who plan services. This situation can lead to culturally inappropriate services, expressions of racism and homophobia, and consequent mental distress.

Work in tackling negative attitudes towards BME and LGBT groups has been undertaken in rural England and Wales at national and local levels. For example, the Countryside Agency's Diversity Review (2005)* researched the diversity-awareness of service providers in rural England and the perceptions of groups who are under-represented in their use of rural services; Mind Out Cymru† provides an all-Wales support and information network for lesbian, gay and bisexual people who either have, or have had, contact with mental health services and Intercom‡ in the South West of England is an umbrella organisation for LGB communities that are dispersed across rural areas.

CHILDREN AND YOUNG PEOPLE

A series of Joseph Rowntree Foundation studies, that form part of their 'Action in Rural Areas' programme (Rugg and Jones 1999; Storey and Brannen 2000; Cartmel and Furlong 2000; Shucksmith 2004), show that issues around employment, housing, education and transport are of particular concern to young people in rural settings. However, there are clear social and environmental benefits for children and young people who live in rural England and Wales. In comparison with their urban counterparts, rural children and young people are generally in better health, living in higher income households and have higher levels of educational achievement (Defra 2005). However, these generalisations hide huge disparities within and between rural communities. Children and young people in lower income families or

* www.naturalengland.org.uk/ourwork/enjoying/outdoorsforall/diversityreview

† www.mind.org.uk

‡ www.intercomtrust.org.uk

in the most sparsely populated rural areas are more vulnerable to the full range of social problems that are likely to affect their mental health.

Children and young people in rural areas have the same rights to health services as those based in urban and suburban areas. Details of these rights for those aged 16 and under are described in the Department of Health's and the Welsh Assembly Government's National Service Frameworks for Children and Young People. All children and young people have the right to specialist, age-appropriate mental health services, flexibility as to the location at which they are seen by health professionals and, if necessary, emergency referrals within 24 hours. In practice, many services are less available in rural areas. Access to specialist services may involve out-of-area referrals which will mean longer waiting times for appointments and longer travelling times to service providers.

YoungMinds* run an information service for parents and carers, and another for children and young people. The service covers all aspects of mental health including diagnoses and conditions, NHS services and legal issues. Many mental health charities run telephone and email support services for children and young people. Examples include Samaritans, Childline† and the Eating Disorders Association.‡ Such services are particularly important for young people in rural areas who do not have access to face-to-face support services.

OLDER PEOPLE

A higher proportion of people aged over 65 live in rural areas. Evidence shows that this proportion is continuing to grow (Commission for Rural Communities 2005; Davies *et al.* 2008). Mental health problems affect a significant minority of older people (Mind 2005) and older men are a high risk-group for suicide. People over 75 are 16 times less likely to be asked about suicide by their GP and five times less likely to be asked about depression (Mind 2009). Older people in rural areas are less likely than their urban counterparts to have relatives nearby to support them and are more likely to live alone. These factors can lead to feelings of isolation. Studies have also shown that older people make up the largest group of people living in poverty in rural areas which, combined with the higher cost of living in the countryside, can cause considerable stress (Mind 2003).

Despite their numbers, older people in rural areas are disadvantaged in terms of health service provision compared with their urban counterparts. Mental health problems experienced by older people are more likely to be misdiagnosed and neglected at primary care level and are less likely to be referred to mental health services.

* YoungMinds is committed to improving the emotional well-being of children and young people by providing expert knowledge, online resources, training, development and outreach. www.young-minds.org.uk

† Childline provides a free and confidential helpline for children and young adults in the UK. www.childline.org.uk

‡ Eating Disorders Association provides information and help on all aspects of eating disorders, including anorexia nervosa, bulimia nervosa, binge-eating disorder and related eating disorders. www.b-eat.co.uk

Contrary to the stigmatising view of older people as 'dependent', evidence shows that older people make a significant contribution to community life in rural areas. They are more likely than other age groups to participate in organisations such as parish councils, village hall committees and religious groups and to use community facilities such as shops and post offices. Older people are also most likely to provide unpaid care to others, including those with physical or mental health problems (Mesurier 2004).

Of the various networks and services that may be of interest to older people living in the countryside, Age Concern is the largest and best known. Age Concern is active in all parts of the country, with many groups located in rural areas.

TRAVELLERS

Travellers have been part of rural communities since the 14th century, when the first Romany Gypsies arrived in England and Wales. Since the 19th century Irish Travellers have joined this population, as well as former house dwellers who have adopted the Traveller life through choice or circumstance. Although economic change has forced many to seek work and accommodation in urban areas, Travellers still make up part of the migrant worker population that takes seasonal employment in the countryside.

Historically, friction has occurred between settled and Traveller populations and this is often the case today. Tensions are further fuelled by the shortage of well-run, authorised sites for Travellers and the negative representation of Travellers in the mass media. This takes its toll on Travellers' mental health and well-being.

Travellers face huge barriers in their access to health and related services, such as social care and education. This is largely because they are subject to frequent evictions from unauthorised sites. As temporary residents in a health authority's catchment area and lacking a fixed abode, it can be difficult for Travellers to register with a GP. This can also make it difficult for them to receive long-term treatment provided by the NHS. There are two main sources of information on Travellers' issues that are relevant to mental health. The Travellers Times* magazine and the Friends, Families and Travellers† website, which gives information on law, planning and evictions as well as health, education and community information.

Traveller communities identify with a holistic concept of health as opposed to medical models that are rooted in concepts of disease and medication. The holistic approach emphasises social and environmental factors as 'key determinants' of health. Using research and outreach into Traveller health undertaken over the past decade, the Department of Health has worked with Traveller communities to establish a model of Traveller participation in the promotion of health and to assist in

* TT Online brings news, pictures, video, opinion and resources from within the Gypsy, Roma and Traveller communities. www.travellerstimes.org.uk

† FFT seeks to end racism and discrimination against Gypsies and Travellers, whatever their ethnicity, culture or background, whether settled or mobile, and to protect the right to pursue a nomadic way of life. www.gypsy-traveller.org

the dialogue between Travellers and Health service professionals, e.g. through the Sussex Travellers Health Project, 2003–2006.*

MIGRANT WORKERS

British farmers depend on migrant workers to perform a range of seasonal tasks. The many thousands of migrant workers who work on British farms and in other agriculture-related businesses are drawn from Eastern Europe, from Asia and the Middle East as well as from Traveller and Gypsy communities.

The mental health of migrant workers, and especially illegal migrant workers, presents particular challenges to service providers. Workers may speak little or no English (nor any of the languages spoken by groups established over a longer period in the UK). They may find British mental health services difficult to understand and even threatening, particularly if they have received hostile treatment from settled local communities. If employed in seasonal work, a migrant worker may not be resident in a NHS Trust catchment area long enough to receive the treatment they need.

Over the past few years, organisations involved with health and well-being have begun working with rural migrant workers. The Citizens' Advice† has undertaken many outreach projects with migrant workers through its Rural Bureau Network. The Arthur Rank Centre, the national focus for rural churches in England, has identified migrant workers as a priority group for pastoral care and has published a leaflet on this issue in partnership with Defra.

Migrant workers' language needs can sometimes be met by a local or national organisation that offers information and support services to a particular national or cultural group, for example, the Chinese Mental Health Association.‡

STIGMA

People with mental health problems are often stigmatised in our society; labelled as violent, unpredictable or dangerous. These negative images and ideas are often caused by confusion about what 'mental distress' actually is. Stigma is particularly associated with regard to mental health issues in rural areas, with high levels of concern around lack of anonymity and confidentiality (Buchan and Deaville 2005). The fear around anonymity is particularly noted by young people living in the most rural parts of Wales (Mind Cymru 2008)

In many rural communities, the stigma can be especially strong – caused in part by social structure. The mental health service user movement is weak owing to population sparsity and consequent lack of group support for those who speak out. This is often compounded by the lack of anonymity or confidentiality found in many

* www.gypsy-traveller.org/health/health-project

† www.citizensadvice.org.uk/index/publications/assisting_migrant_workers

‡ The Chinese Mental Health Association (CMHA) specialises in providing community-based mental health assistance and support to the Chinese community, in an attempt to assist those in need. www.cmha.org.uk

small, close-knit rural communities. In a wider sense, many rural communities have a deeply ingrained culture of stoicism and self-reliance. This can apply to all aspects of a person's life, including their health. Stoicism and self-reliance have proved great strengths in the countryside, enabling individuals and families to survive major financial and personal difficulties, to persevere and even prosper. However, stoicism and self-reliance can sometimes have a negative effect on mental health. Where these qualities are highly valued, external intervention – especially from public, urban-based health services – is likely to be rejected in favour of trying to cope alone.

The consequences of stigma can have a serious effect on a person's willingness to access mental health services or confide in potentially supportive individuals and agencies. In this atmosphere, mental health problems are more likely to develop and recovery is more difficult. This can lead to chronic poor mental health.

Fortunately, attitudes to mental health have improved across the countryside over the past decade. High profile crises in agriculture, such as BSE and foot-and-mouth disease, have brought public attention to the stresses in farming communities that can lead to mental health problems. Rural organisations which have a mental health remit, such as the Farm Crisis Network, the Arthur Rank Centre* and Farming Help† have been active across England and Wales.

Having outlined some of the issues around rural mental health and drawn some attention to the specific concerns for rural men, it is important now to explore how this relates to notions of masculinity; that is, to how it relates to ideas about what it is to 'be a man' in the rural context.

RURAL MASCULINITIES AND MENTAL HEALTH

Several chapters in this book highlight how traditional, stereotypical images of men are built on notions of strength, rationality, self-control/sufficiency and stoicism. These are the very same values, what some have termed 'agrarian values', which are suggested as shaping rural and particularly male rural identities (Campbell and Bell 2000; Judd *et al.* 2006). The stereotyped image of the rural man therefore almost constitutes a hyper-masculinity. It combines notions of (often extreme) physical action (labour) and endurance with a rational mind that can overcome adversity through the ability to adapt and be decisive (Liepins 2000). Changes in wider socio-economic circumstances clearly affect the way that these ideals become expressed, with some suggesting a shift from rural men as dirty, manual workers to organised businessmen willing and able to diversify in order to maximise family income (Brandth 1995; Bryant 1999). The shift in the way these ideals are expressed may be even more profound when viewed through the perspective of the new rural definition with less than

* The Rural Stress Helpline at the Arthur Rank Centre provides a confidential, non-judgemental listening services to anyone in a rural area feeling troubled, isolated, anxious, worried, stressed or needing information. www.arthurrankcentre.org.uk.

† Farming Help brings together three national charities which work to benefit the farming community. Each charity provides different but complementary forms of help and support to meet a wide range of needs. www.farminghelp.org.uk.

1.5% of the UK working population employed in agriculture. Most likely though, these seemingly contradictory masculine identities often continue to sit beside one another with rural men choosing to, and also having to, shift between them at various times (Evans 2000; Little 2002; Coldwell 2007).

In terms of mental health, these stereotyped (and often idealised) images of rural masculinities create a double bind for rural men. The pressure of living up to these images can readily take its toll in terms of increased stress and anxiety that becomes internalised when notions of showing weakness are seen as unacceptable.* Work on understanding suicide in farmers confirmed this, with farmers identifying that they had limited capacity to acknowledge or express the stressors they experienced and that this was related to specific attitudes the men held around 'maleness' and help-seeking (Judd *et al.* 2006a). On the other hand, not living up to these stereotypes, through circumstance or choice, may also generate significant stress, depression and suicidal ideation. The current stressful context for farmers, outlined above, of new legislation, increasing paperwork, financial pressures and media criticism can overwhelm individual men. This can create feelings of hopelessness, entrapment, isolation and loss of control, which are significant factors in suicide associated with men living in rural locations (Ni Laoire 2001). As Coldwell (2006) identifies, failing as a farmer means being seen to have failed to live up to the expectations of family and community members. Farming masculinities therefore entail a constant struggle to perform in order to survive and maintain one's identity in a culture where to fail as a farmer means to fail as a man.

This rural 'hyper-masculinity' is also linked to heterosexuality (Little 2003) and for those specifically choosing to reject these rural male stereotypes, such as rural gay men, there may be specific concerns about the impact on mental well-being when structural difficulties are experienced (Bell and Valentine 1995). The mental health impact of life events may be compounded by the stigmatisation attached to others, homophobic attitudes (Ross 1990) and these attitudes may be more apparent in hyper-masculine rural contexts.

Factors affecting men's mental health and well-being often have higher impacts on the mental health and well-being of men in rural areas, due to such factors as isolation, lack of alternatives, the stigma surrounding mental health and the issue of socialisation theory. The theory may explain why some men find it very difficult to articulate their feelings and seek help (Mind 2009). Men are also more likely to get angry when worried and often 'act out', whereas women are more likely to 'act in'. As the principles for diagnosing depression are more focussed on 'acting in' behaviours they can be seen as feminised (Kilmartin 2005). This may make engagement with men much more difficult, particularly in rural areas, given the additional barriers referred to here.

* It can also take its toll physically with some research showing farmers to be a 'high risk' group in terms of health and safety (Gerrard 1998).

CONCLUSION

Rural environments bring with them particular challenges in relation to a range of issues such as employment, housing, transport, access to education and healthcare. These can be compounded in times of economic hardship and specific crises (such as foot-and-mouth, BSE, etc.). There is no doubt that these hardships create particular concerns and outcomes in relation to mental well-being for those in rural settings. Despite some evidence of lower psychiatric morbidity, it is likely that rural identities and 'resource drift' to urban locations hide the reality of the levels of mental health concerns in these settings. In addition, such concerns, particularly stress, depression and suicide, are experienced differently by men and women in rural contexts. The links between the values attached to stereotypes of 'masculinity' and those attached to stereotypes of 'rural' identity – strength, rationality, self-control/sufficiency and stoicism – can create a 'hyper-masculine' rural identity. In turn, this creates challenges for rural men's mental well-being in terms of the stresses involved in living up to such idealised stereotypes or the disappointment and hopelessness that can come of being unable (or unwilling) to live up to them.

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