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Rural mental health

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Abstract A significant proportion of people live and work in rural areas, and rural mental health is important wherever psychiatry is practised. There are inherent difficulties in conducting rural research, due in part to the lack of an agreed definition of rurality. Mental health is probably better in rural areas, with the exception of suicide, which remains highest in male rural residents. A number of aspects of rural life (such as the rural community, social networks, problems with access, and social exclusion) may all have particular implications for people with mental health problems. Further issues such as the effect of rural culture on help-seeking for mental illness, anonymity in small rural communities and stigma may further affect the recognition, treatment and maintenance of mental health problems for people in rural areas. Providing mental health services to remote and rural locations may be challenging.

Rural culture and countryside form a significant part of our society. A large minority of the British population lives in rural places: around 30% in England and Wales, and 20% in Scotland. Most (98%) of Scotland's landmass is classified as rural. The degree of rurality differs between different countries, but remains significant in the world's high-income countries; for example, in the USA 25% of the population and 90% of the landmass are considered to be rural. Despite this, our way of life remains predominantly urban. Services such as healthcare, higher education, transport and communication links are all centralised, and people living in rural areas are generally expected to travel to urban centres to access them. Government policy has for the most part reflected this urban bias.

Although it is not often thought of in these terms, psychiatry in the UK is likewise a predominantly urban specialty. Large units and inpatient facilities are usually based in cities, and services serving rural communities are centralised as far as is possible. Psychiatric research is almost entirely conducted on urban populations, although we rarely consider this. Yet a large proportion of the patients with whom psychiatrists work live in rural places, and their life experiences may well relate to their rural environment. Geographic mobility within the UK is relatively high, and patients commonly move between urban and rural environments. Many of the issues identified within rural research – such as difficulties in accessing services and maintaining anonymity within a small community – are also pertinent to patients in urban areas. Rural mental health is important wherever psychiatry is practised.

Background and historical context

Although most great nations have been built around cities, the bulk of the population lived off the land, and it is only in the past couple of centuries that industrialisation has brought a majority of people into towns and cities. The effects of the industrial revolution started to be felt in the UK in the latter half of the 18th century, and in much of Europe and North America shortly after. In other parts of the world, the process of industrialisation is not yet complete, and some countries are continuing to experience rapid urbanisation as a consequence (Goldberg & Thornicroft, 1998).

This article concerns itself with the research that has developed as people have tried to identify and study the features that differentiate 'urban' from 'rural'.[1] I explore this almost entirely from the rural perspective. There is a large literature looking at different aspects of urban life; but there is surprisingly little overlap with rural research, or indeed acknowledgement that the concept of rurality only makes sense as the counterpart of urbanicity.

1. For a copy of the article with a more complete list of references, please contact the author.

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Defining rurality

Although the idea of rurality appears conceptually simple, there is no universal agreement about what it actually means. In the past, research tended to present a dichotomy in which 'rural' was everything that was 'not-urban', but recent classification systems have tried to identify the degree of rurality and urbanicity. There are no *a priori* theoretical grounds for developing such a classification system, but definitions can be broadly divided into spatial, socio-economic and sociological (Table 1).

Spatial classifications depend on factors such as population numbers, population density, and distance to cities and other urban centres.

Socio-economic classifications look at factors such as the principal employment in an area (for example, farming *v.* financial) and other socio-economic characteristics of the population. Service-based definitions have been used in healthcare (for example, defining rural primary care by identifying the perceived differences between urban and rural general practice).

Sociological definitions consider the subjective aspects and experiences of rurality; for example, asking the study participant or researcher to decide for themselves whether they would define themselves as rural. Although pure sociological definitions tend to be less used in mental health research, unless a system of classification considers the look or feel of a place, people included in the research may disagree about the findings. It may be useful also to include rural attributes such as community cohesion, stoicism and self-sufficiency in a definition of rurality.

More complex definitions combine several of the above aspects.

'Rurality' and research

There is no evidence-base to suggest that any of these ways of defining rurality is superior to any other; however, the choice of definition may substantially affect the results of research. For example, using different definitions of rurality generates different proportions of rural population (Australian Institute of Health and Welfare, 2004), and even if the overall proportion is similar, different people within the sample will be described as rural (du Plessis *et al*, 2002). Whether infant mortality is found to be higher in urban or rural areas depends on the definition of rurality that has been used (Farmer *et al*, 1993). Several researchers have suggested that the whole concept of rurality in research is mostly useful as an aid to helping develop healthcare and other social policy.

Rural environments differ greatly around the world, and this has led to the suggestion that different definitions are required in different countries. In keeping with this, most high-income countries have now established one (or a small number) of agreed definitions for use within their own regions. Unfortunately, these are sufficiently dissimilar that comparisons of international research are extremely tricky. Even within a single country, the

Table 1 Different ways of defining rurality

Spatial	*Socio-economic*	*Sociological*
Total population/settlement size	Availability of healthcare and other services	Self-classification as rural or urban
Population density	Income levels	Attractiveness or beauty of landscape
Distance or journey time needed to travel to nearest metropolitan centre	Unemployment levels	Community support and cohesion
Isolation, and distance to nearest neighbour	Transport links	Self-sufficiency and independence
Number of miles of road per 1000 population	Mobile phone, internet and other communication links	
Proportion of green space (compared with other types of land cover such as domestic buildings, gardens, non-domestic buildings, roads, railways, paths, water)	Principal economic activity (e.g. farming or fishing)	
	Predominant land use (e.g. farming)	
	Cost of providing services	
	Relationship to the nearest metropolitan area (e.g. the proportion of commuters, or the proportion of population that access centralised services)	

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rural environment may be quite diverse, and it may not make sense to compare the environment of a crofter living on a remote Scottish island to that of a commuter in Essex. There is an increasing tendency to distinguish both rural and remote, where the term remote is used purely to denote geographic distance, and this may be helpful in further defining rurality, as rural locations may range from a few miles to a few hundred miles from an urban centre. Even then, the concept and reality of remoteness varies greatly between different countries. The Scottish Executive defines places as remote if they are greater than 1 hour's drive from a settlement of 10 000 or more. In Alaska, around a third of the population lives in places without road access, and places are defined as remote when they can be reached only by boat, aeroplane or snowmobile.

It is essential to know how rural has been defined when evaluating rural research. For research that will be used to influence health services and policy, it is probably best to use the accepted classification system for the country concerned. With exploratory research, or comparative international research, it may even be best to return to the simple dichotomy of 'urban' and 'not-urban'.

There is relatively little research looking at rural mental health in the UK, and in this article I have drawn heavily from the international literature. The primary findings and underlying concepts may therefore be valid, but because rurality differs so much between countries, it is always necessary to reflect how these might apply in general to the UK population, and more specifically to the community in which the psychiatrist works.

Given the inherent difficulties in defining rurality, it could be argued that it is simply not a useful concept either for research purposes or in clinical practice. However, the concept of rurality has both face value and utility. At government level it can be used to drive policy decisions and address inequalities in society. At an individual level, it is helpful to think about the meaning of rurality when working in a rural environment or with rural patients. It can also be useful to consider what features have been used to identify a patient as rural, and how their rurality may affect their illness and treatment. If we ignore the concept of rurality we will neglect a major element of the complex society in which we live.

Rural research

Several authorities on rural healthcare have identified an international deficit of rural research. Furthermore, that which has been carried out is often of relatively low quality, comprising mainly small localised studies, case studies and expert opinion (Buchan & Davies, 2005). A number of problems inherent in conducting rural research contribute to this deficit. Foremost are the cost and practical logistics of working over large areas with small and dispersed populations. It can be difficult to standardise information collected from a wide geographical range of sources, and because of small numbers, data are often pooled over larger areas. Confidentiality within a small community may be harder to maintain, and if research is published, this may be another reason for having to amalgamate data. It is difficult to conduct large-scale research outside a university or comparable research environment, and these are almost inevitably based in cities. Finally, as described above, the concept of rurality is difficult to identify and define.

There is very little international rural research from low- and middle-income countries; in any case, the whole concept of rurality may differ greatly in countries where the infrastructure and lack of access to centralised services bear less relationship to where people live (Couper, 2003). Most literature in the field of rural mental health confines itself to a small number of high-income countries with formal mental health services, and where the availability of psychiatrists and specialist mental health practitioners approximates that recommended by the World Health Organization (Judd *et al*, 2002). There is also very little research investigating ethnicity or ethnic minorities in rural areas.

Epidemiology of rural mental health

Numerous studies have tried to address the issue of whether there is a fundamental difference between urban and rural mental health. However, many factors affect rural mental health and the provision of rural health services, and it can be difficult to identify what exactly the studies are measuring. For example, several studies use utilisation of psychiatric services (for example, admission to psychiatric hospital) as a proxy measure for psychiatric morbidity, but this may be influenced by factors such as the lower availability of services in rural areas. The threshold for referral to hospital may differ in rural areas, as may the willingness to manage psychiatric illness in the community – especially if assessment for admission would entail a long journey. Demographic and socio-economic factors differ in rural communities, so unless research adjusts for these potential confounders, the results should probably be interpreted with caution.

Even if these issues can be addressed, there are further problems inherent in mental health research, such as defining and measuring mental

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ill health in an international context. This has led some researchers to the conclusion that rather than continuing the 'long and somewhat unproductive debate' as to 'whether and how much' urban and rural mental health differ, it might be more helpful to focus our attention on researching issues such as access, infrastructure and cultural differences (New Freedom Commission on Mental Health, 2004).

Notwithstanding all of these difficulties, on balance research would suggest that mental health is probably better in rural areas. The evidence is strongest for psychosis and in particular schizophrenia, which (with the exception of a single study looking at psychotic symptoms in the community (Wiles *et al* 2006)), has consistently shown a lower incidence and prevalence in rural areas (Lewis *et al*, 1992; Pedersen *et al*, 2001; van Os *et al*, 2001). This has led to important speculation and further research into the aetiological factors contributing to schizophrenia. There is also evidence that the incidence and prevalence of 'common mental disorders', including depression and anxiety disorders, are either lower in rural areas (Paykel *et al*, 2003; Weich *et al*, 2006) or that there is no difference (Eckert *et al*, 2006; Parikh *et al*, 1996). Likewise, substance misuse has been described as either lower in rural areas (Bilj *et al*, 1998; Caldwell *et al*, 2004) or at least comparable between rural and urban places (Blazer *et al*, 1985; New Freedom Commission on Mental Health, 2004). This is probably explained at least in part by the easier access to drugs in cities.

Most of the more recent studies comparing urban and rural mental health adjust for the age and gender of participants, but fewer adjust for potential confounders such as unemployment, socio-economic status, ethnicity, educational status and marital status. Some studies report both adjusted and non-adjusted results; once the additional confounders are adjusted for, the results are generally less strong, or in some cases disappear altogether (Eckert *et al*, 2006). Weich *et al* (2003) defined rurality using a number of these confounders, which may explain why the results of this study failed to show any difference between rural and urban areas. It may also explain why, when they subsequently reanalysed their data (Weich *et al*, 2006), although the results now came out in favour of rural mental health, further adjustment for the confounders made no difference to their findings.

In contrast to the more variable results just discussed, suicide in men has been consistently shown to be higher in those living in rural areas. This may relate at least in part to rural deprivation (Singh *et al*, 2002). Another fairly constant finding is that the prevalence of intellectual disability (also known as learning disability in UK health services) is higher in rural areas (Wellesley *et al*, 1992).

Even if there is a true difference in rural and urban mental health, the magnitude of any difference is likely to be small. However, studying rural and urban differences may still be valuable to the extent that it helps develop insight into the aetiology and maintenance of mental health problems. Confounders may be more important than rurality *per se*. This may be a particularly useful finding, as variables such as unemployment and poverty are more amenable to intervention than is rurality.

Geographic mobility and rural 'incomers'

The majority of rural research assumes that the boundaries between the rural and urban environment are relatively fixed and inflexible. In reality, not only do the boundaries themselves change, as rural areas become absorbed into larger conurbations, but there is a constant flux of people from one place to another. The traditional 'rural' community is likely to comprise a mixture of locals and 'incomers', and this has implications, for example, when trying to measure the true prevalence of 'rural' mental health. With the exception of urban drift theory in schizophrenia, very little research has considered the patient's place of birth rather than their current place of residence. There is even less research comparing the mental health of incomers and locals in rural areas – even though attitudes to mental health, help-seeking behaviours and actual mental health may different greatly between these two groups.

In addition, an individual's geographic mobility might itself be related to their mental health. Perhaps those with mental health problems are more likely to move from place to place, unable to settle within a community? Alternatively, perhaps those with greater geographic mobility are more likely to develop mental health problems because of the lack of social stability in their lives?

Unfortunately the evidence base looking at mental health and geographic mobility is limited. There has been a growing interest in the mental health of immigrants, but the effect of migration between countries is likely to be confounded by factors such as language barriers, financial difficulties and cultural differences, and research in this area is unlikely to reflect geographic mobility within countries. Severe mental illness (in particular frequent hospitalisation of people with chronic schizophrenia) has been associated with homelessness and frequent changes of address (Lamont *et al*, 2000; Lix *et al*, 2006), but research into the association between geographic mobility and psychiatric symptoms and illness managed within the community has been less conclusive. There may be an association between

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suicidality and high geographic mobility (Potter *et al*, 2001). Finally, there is some evidence that those with chronic mental health problems may drift towards urban centres because of a decline in social status or to access mental health services (Goldberg & Morrison, 1963; Breslow *et al*, 1998).

Aspects of rural life

The rural environment

From the time of the Ancient Greeks, rurality has been associated with the pastoral idyll, and even today there is a widely held view that rural life is healthy and wholesome (Countryside Agency, 2004). This relates in part to characteristics of the natural landscape: the attractive environment (Scottish Executive, 2006) and sense of space and independence (Department for Environment Food and Rural Affairs, 2000) are valued by rural residents. In addition, rural places are considered to be quiet and peaceful, and the rural population reports experiencing less antisocial behaviour. They feel relatively safe compared with people living in more urban environments. Perhaps this is why in the UK, people tend to want to live in the countryside, and both urban and rural residents would rather live in a less urban environment (Scottish Executive, 2006).

The problem with this stereotyped myth of rurality as a haven and retreat from hectic strains of urban life is that it prevents deeper exploration of the reality of rural life. Although there are undeniably many benefits of living in the countryside, there are also disadvantages, and these may be masked by an unrealistic or overly positive vision of the countryside. Also, what may be considered an advantage for some may be a drawback for others. A sense of space may be experienced as liberating and invigorating, but it can also be experienced as isolating and frightening.

Community

Crow & Allan (1994) define community as the social arrangements that we engage in that are beyond the private sphere of home and family but are more personal than the wider institutions of society. Communities can take many different forms and structures, but all communities need some type of common or shared experience to develop the sense of belonging that allows communities to function (Box 1). It can be helpful to think of communities as being divided into:

- 'place communities' (in which people live in a particular location)
- 'interest communities' (in which people share a common interest or experience)
- 'communities of attachment' (in which, for whatever reason, people feel that they have a shared identity).

Box 1 What makes a community?

- Common interests
- Living in the same place
- Shared life experiences
- Ethnic or cultural background
- Shared attachments
- Religion
- Occupation

There may of course be considerable overlap between these three types. The 'rural community' is usually taken to refer to a 'community of place'. In fact, the rural community may exist in many forms, and the 'community of interest' (for example, to maintain sufficient infrastructure and services to continue to exist as a small rural community) may create a far stronger tie than that simply created by the shared location. In the UK, rural areas increasingly accommodate a large number of commuters; their 'community of place' will hold a very different meaning from that of people who both live and work within the rural community.

Rural life has traditionally been coupled with the rural community, and some research supports the view that the rural community is somehow stronger or better than the urban community. For example, there may be a stronger sense of community or community spirit in rural areas and people living in rural areas are more likely to feel included in their local community (Gething, 1997; Scottish Executive, 2001). However, there are other studies that show the continuing vitality and identity of communities in urban contexts (James *et al*, 2007). Belonging to a community is generally considered to be good for social, emotional and physical health, but romanticising the concept of community life ignores the downsides of belonging to a community, such as loss of anonymity and independence (Chavis & Newborough, 1986). A strong rural community may be beneficial to those within it, but at the expense of those who have been excluded.

Social networks

Social networks are composed of the multitude of formal and informal social links between the different members of a group. Social networks can vary according to characteristics such as the number,

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strength and importance of the links between group members. They differ from communities in that the focus of social networks is on the links and connections between the members in a group rather than the group as a whole. Nevertheless there is a degree of conceptual overlap. As with belonging to a community, having a large and robust social network is generally seen as beneficial, and social capital is associated with well-being (Crow, 2004). In the UK, recent social policy aims to enhance social networks and social capital as a means of developing social inclusion and improving communities. Among other initiatives, government schemes have been set up to increase volunteering and participation in other community activities (Haezewindt, 2003).

As with communities, social networks may also have drawbacks. A closed social network may limit its members from taking up opportunities from outside the network, and social networks may reinforce social divisions by excluding people. Social networks are an important source of social support for people, but with that support comes an obligation to adhere to the unwritten rules of the network. Support received through a social network usually entails a sometimes unwelcome obligation to reciprocate that support. Dependence on a social network may stifle autonomy and freedom in the larger society.

It is difficult to measure social networks, and there is no single accepted means of doing so. Perhaps this is one reason why, despite the common assumption that rural communities have superior social networks and provide more social support than urban communities, there is very limited evidence within the healthcare literature to support this. However, at least among elderly people, those living in rural areas may benefit from having larger social networks (Magliano *et al*, 2006). Even though formal support may be less available in some rural areas, perceived informal support may compensate for this (Weinert & Long, 1987).

Rural deprivation

Until recently, rural deprivation had been largely overlooked by both the government and the research community. This may relate to the understandable concerns about severe inner-city deprivation in combination with the image of the countryside as being relatively affluent. As a whole, rural areas are probably less deprived than urban areas, but within them exist distinct pockets of deprivation and disadvantage. These may go unrecognised as a consequence of averaging out measures of deprivation over larger areas and population bases. Also, measures of deprivation were developed for use within urban communities, and may not be as sensitive to rural deprivation (Box 2). For example, in the UK, overall employment and self-employment is higher in rural areas, but part-time and seasonal or casual work is more common, and average earnings are less. The cost of living is higher in rural areas, with affordable housing an increasing concern, and disposable income may therefore be lower. Having a car in a city may be a luxury, but in the countryside it may be a necessity, and is a less useful indicator of wealth.

Box 2 Common indices of deprivation

- Income
- Unemployment
- Household overcrowding
- Car ownership
- Social class
- Health indicators
- Access to services
- Educational achievement

Access

Access is a complex issue. To be fully accessible, not only must a service be available, but it must also be acceptable. People must have a reasonable knowledge about the service that is being provided, or at the very least need to be aware that it is available. In the case of healthcare, a person's health-related beliefs must include the possibility that accessing the service is both necessary and important for their health. The ability to pay for a health service is less central in the UK, but in some parts of the world, this may be the overriding factor limiting access. Finally, and even if all of these barriers to access can be overcome, a person must still have the means to physically take themselves to the place where the service is located.

There is a wide literature looking at the poorer access and availability of a range of services in rural areas. This includes access to healthcare, employment, shops and banking facilities, education and training opportunities, leisure and recreation, and social care (Dixon & Welch, 2000; British Medical Association Board of Science, 2005; Hart *et al*, 2005). Transport is a major factor, and as public transport is rarely adequate, a car may be essential to access rural services. However, access does not only relate to transport and distance. For example, if a person has to travel a long way for hospital treatment, they may miss employment, and if the treatment is prolonged, they may have to spend time away

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from family and friends. There are financial and social implications, and the inconvenience may be far greater than if the service were accessed from an urban area. Rural perceptions of health and health-seeking behaviour as further barriers to accessing services are discussed in more detail below.

Social exclusion

Social exclusion has a number of different meanings. In this article the term is used to describe the situation where an individual is unable to participate fully in key aspects of society. Key activities may include (Burchardt *et al*, 2002):

- purchasing goods and services
- participating in economically or socially valuable activities
- influencing the future by engaging in local or national decision-making.
- engaging in social interaction with family, friends and community.

Social exclusion may be influenced by many factors. For example, a person may be excluded because of their gender, their ethnicity or because they have a disability. Several authors have written about rural social exclusion in the UK, and it is easy to envisage how the combination of unavailable services, poor access and low disposable income could all contribute to social exclusion from the key activities described above.

Several factors may interact to make an individual even more excluded from participating fully in society – for example, a single parent living in a rural area may be unable to find local well-paid full-time employment with adequate child care facilities. As a consequence, she may be unable to afford to buy a car that might have facilitated access to more distant employment. Without a car, she may become increasingly isolated from friends and family, and prejudice against single parents may further limit her participation in a small rural community. Once a person has become socially excluded from society, it may become increasingly difficult to rejoin it again, and the person may become trapped indefinitely on the margins of society.

Particular difficulties experienced by people with mental health problems in rural areas

Deprivation, access, social exclusion and segregation from the community (as discussed above) may all differentially affect people with mental health problems living in rural areas (Philo *et al*, 2002; Elder, 2004). For example, a mental health problem may prevent an individual from driving. This in turn may seriously limit access and opportunity, and contribute to social exclusion. Other factors that may be particularly relevant for people with mental health problems include the following.

Perception of health and help-seeking

Seeking help for mental health problems does not depend solely on the availability and access of services. First of all, distressing symptoms must be recognised as a mental health problem. This will depend on knowledge about mental health, but also on cultural factors within the community that affect how mental illness is perceived and accepted. The isolation of remote and rural communities may produce a culture of self-reliance and stoicism towards health problems.

Qualitative research in Australia suggests that within the rural community, mental illness is equated with severe mental illness such as psychosis requiring detention; other symptoms of mental illness are more likely to be attributed to problems such as financial worries (Fuller *et al*, 2000). Likewise, research in rural Scotland (Scottish Executive, 2001) found that stress, anxiety and depression were less likely to be recognised as mental health problems requiring treatment. A comparative study found that young men with mental health problems in rural Australia were less likely to seek help than their urban counterparts (Caldwell *et al*, 2004). This may be one explanation for the finding that there appears to be a lower prevalence of mental health problems in rural areas, and may identify a significant unmet need in rural communities.

Anonymity and confidentiality

Rural neighbourhoods often comprise small tight-knit communities, in which most people are relatively well-known to each other. It can be extremely difficult to keep mental illness hidden because of social visibility and rural gossip networks (Aisbett *et al*, 2007). Some families may try to protect their relatives from loss of anonymity by hiding their illness, and refusing them access to mental health services. If the location of mental health facilities is easily identifiable, this can cause further difficulties. Patients may refuse to let mental health workers carry out domiciliary visits, for fear of recognition, especially if the mental health worker is well-known or lives locally. General practitioners may be considered to be part of the rural community, and because of this relationship, some people may be embarrassed to admit to mental illness.

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Stigma

Stigma towards mental illness is consistently identified as a problem in rural communities, despite widespread community education programmes. It is directed both towards people with mental health problems and towards mental illness in general. Stigma may also be an issue in urban communities; unfortunately there are no high-quality studies comparing the extent of stigma towards mental illness in urban and rural areas. Also, despite the increased stigma of mental illness, many rural communities tolerate markedly eccentric individuals to a degree that would be unusual in other settings.

Service provision and mental health services in rural areas

A number of factors contribute to the difficulty in providing services to rural locations. This includes mental health services, which may also face more specific problems. Key factors affecting the provision of mental health services in rural areas include the following.

Cost

It costs more to provide services in rural areas for a number of reasons. Transport for staff and patients have both direct financial costs and indirect costs in terms of travel-time. Low numbers mean that savings cannot be made through economy of scale, and providing 24-h cover and emergency services for a smaller population is more expensive. Unless higher costs are accounted for by central funding, rural services remain relatively underfunded.

Staff recruitment and retention

There may be difficulties with recruitment and retention of staff in rural areas. People may be reluctant to accept a short-term post in a distant location, preferring to remain in a larger centre with a wider potential employment pool. Family considerations, such as finding employment for a spouse or higher education for children may play a role. Small units may necessitate unacceptably high on-call commitments.

Extended professional roles

Professionals working in rural areas have extended services roles compared with their urban counterparts. This has been particularly studied with reference to primary care and the role of general practitioners, but it applies equally to psychiatry. Rural psychiatrists may not be able to refer to the local liaison team or other specialist service, especially out of hours. This affects not only psychiatrists, but also other members of rural multidisciplinary teams.

Boundary issues

Living and working in the same small rural community has the potential for role conflicts and boundary issues. Psychiatrists are likely to meet their patients outside a hospital or clinic setting.

Patient choice

There is often limited choice of healthcare professional in rural areas, and a single psychiatrist and community psychiatric nurse may cover a large geographical area. Changing psychiatrist may not be a feasible solution to conflict, especially if the patient does not have access to a car. Even requesting a second opinion may be problematic if the patient is unwilling to travel. Problems may arise when more than one member of a family requires psychiatric input from a small mental health team.

Professional isolation

Working in remote places can lead to professional isolation, and it may be difficult to attend centralised further training. At present in the UK, psychiatric specialist training programmes are all based in urban areas.

Conclusions

Rural mental health is a complex issue that has many ramifications and implications for those working within psychiatry. A greater understanding of the issues involved can give psychiatrists a better understanding of mental health in general, and may lead to improved working practice with patients and colleagues from rural areas.

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Declaration of interest

None.

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MCQs

1 The proportion of the UK population that lives in rural areas is roughly:
a 2%
b 5%
c 10%
d 25%
e 40%.

2 As regards the definition of rurality:
a the international research community has agreed on a standardised definition
b rurality is best thought of in terms of population density
c the definition of rurality is based on a strong theoretical construct
d the concept of rurality may differ greatly between different countries, and even within the same country
e it does not make much difference how rurality is defined when conducting and analysing the results from rural research.

3 As regards rural healthcare:
a it costs more to provide services in rural areas
b it is generally easy to recruit staff to work in rural areas, as people want to live and work there
c there is often more patient choice of healthcare in rural areas
d it is easier to maintain professional boundaries working in a rural community
e healthcare providers in rural areas often have more specialised roles than their urban counterparts.

4 Compared with urban areas, rural areas have a higher prevalence of:
a schizophrenia
b depression
c anxiety disorders
d substance misuse
e suicide.

5 As regards mental illness in rural areas:
a stigma towards mental illness is not generally an issue
b it is easy to maintain confidentiality and anonymity
c people living in rural areas may be less likely to identify symptoms of stress as mental illness
d people living in rural areas are more likely to seek help for mental health problems
e markedly eccentric behaviours are never tolerated by rural communities.

MCQ answers

1	2	3	4	5
a F	a F	a T	a F	a F
b F	b F	b F	b F	b F
c F	c F	c F	c F	c T
d T	d T	d F	d F	d F
e F	e F	e F	e T	e F

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