Canadian Collaborative Mental Health Initiative

Initiative canadienne de collaboration en santé mentale

Establishing collaborative initiatives between mental health and primary care services for *rural and isolated populations*

A companion to the CCMHI planning and implementation toolkit for health care providers and planners

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Establishing collaborative initiatives between mental health and primary care services for *rural and isolated populations*

A companion to the CCMHI planning and implementation toolkit for health care providers and planners

A Toolkit

February 2006

OUR GOAL

The Canadian Collaborative Mental Health Initiative (CCMHI) aims to improve the mental health and well-being of Canadians by enhancing the relationships and improving collaboration among health care providers, consumers, families and caregivers; and improving consumer access to prevention, health promotion, treatment/intervention and rehabilitation services in a primary health care setting.

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Preface

Welcome to the CCMHI Toolkit Series!

The Canadian Collaborative Mental Health Initiative (CCMHI) is led by 12 national organizations representing community services; consumers, families and caregivers; self-help groups; dietitians; family physicians; nurses; occupational therapists; pharmacists; psychiatrists; psychologists; and social workers. Funded through Health Canada's Primary Health Care Transition Fund, the goal of the CCMHI is to improve the mental health and well-being of Canadians by increasing collaboration among primary health care and mental health care providers, consumers, families and caregivers.

The CCMHI toolkits contain practical tools to:

- Assist providers and planners in the implementation of collaborative initiatives.
- Help mental health consumers and their family members understand mental illness and work with other members of the care team.
- Inform educators of the benefits of interprofessional education and provide tools to teach about collaborative mental health care.

Each toolkit was developed with an interprofessional expert panel and guided by a working group representing a number of key stakeholder groups. We hope that readers of any of the toolkits in the series will recommend them to others (e.g., consumers referring toolkits to their providers and vice versa).

In addition to this series of 12 toolkits, the CCMHI has developed a Charter of principles and commitments that will influence the future of mental health care in Canada and a series of reports that capture the current state of collaborative mental health care. The reports highlight health human resource issues, provide an annotated bibliography, summarize best practices, review initiatives from across the nation and summarize provincial and territorial mental health and primary care reform. These documents guided the development of the toolkits and are available at www.ccmhi.ca.

Implementation toolkits

Collaboration between mental health and primary care services. A planning and implementation toolkit for health care providers and planners is a guide for providers wishing to establish or enhance the mental health services they provide through collaboration. This general toolkit offers readers a guide to all aspects of planning, implementing and evaluating a collaborative mental health care initiative, including assessing need, setting goals and objectives, developing a budget, building a team, maintaining a well-functioning team, managing change and monitoring the initiative.

Eight population-specific toolkits, entitled *Establishing collaborative initiatives between mental health and primary care services*, are designed to be used in conjunction with the general toolkit. They offer tips on adapting the general toolkit for Aboriginal Peoples,

children and adolescents, ethnocultural populations, rural and isolated populations, seniors, individuals with serious mental illness, individuals with substance use disorders and urban marginalized populations. There is some overlap in the toolkits; for example, information about collaborative mental heath care and the homeless may be found in at least three toolkits: individuals with serious mental illness, individuals with substance use disorders and urban marginalized populations. Readers are encouraged to consider all the toolkits that may be relevant to their needs.

The general and population-specific toolkits are not intended as clinical practice guides but offer practical advice on different aspects of establishing successful collaborative initiatives.

Consumer, family and caregiver toolkits

Consumers, families and caregivers developed both of these toolkits for consumers and their loved ones.

Working together towards recovery: Consumers, families, caregivers and providers is intended for all consumers, families and caregivers wishing to know more about mental health and mental illness, how to access services and the type of professionals that can assist them in their recovery. This toolkit also offers an outline of complementary therapies and self-care as well as the contributions and needs of caregivers. Finally, this toolkit includes a guide to "getting involved", describing how government and boards of directors work, and why consumers and families should participate.

Pathways to Healing: A Mental Health Guide for First Nations People is a toolkit that offers a basic overview of mental health and mental illness along with a contextual section outlining the impact of history, social, economic and political conditions on the mental health of these peoples. There are tools in this toolkit to foster holistic care.

Education toolkit

Strengthening Collaboration Through Interprofessional Education: A Resource for Collaborative Mental Health Care Educators serves as an educational resource to assist in the implementation of educational initiatives and programs that promote collaborative mental health care in primary health care settings. The toolkit is targeted to education program developers in regulatory agencies, professional associations, regional health authorities, family health teams, governmental departments, and educators within both academic (universities and colleges) and care delivery settings.

This toolkit highlights the importance of interprofessional education in promoting collaborative care. It offers four case studies and several activities accompanied by a sample lesson plan and other useful tools to aid educators in the implementation of educational events.

Executive summary

Introduction

Individuals living in rural and isolated areas are a culturally unique and diverse population. Despite this diversity, rural and isolated communities share common problems in terms of health status and access to health care. Most provinces and territories show a trend towards progressive deterioration of health the greater the distance from urban areas: lower life expectancy than the national average; higher rates of disability, violence, poisoning, suicide and accidental death; and more mental and physical health issues than their urban counterparts. When considering rural and isolated populations in Canada, it is particularly important to look at the needs of Aboriginal Peoples since they constitute one of the largest segments of isolated populations.

The purpose of this toolkit is to encourage greater collaboration among primary health care professionals, mental health care professionals, consumers, families and community organizations in addressing the primary mental health care needs of individuals living in rural and isolated parts of Canada. Highlights of the toolkit include: a guide to providing effective collaborative mental health care in rural and isolated areas; seven key points for consideration; descriptions of six positive practice initiatives; and key tools and resources.

Defining the population

There is no standardized definition of rural and isolated populations. Aspects relating to the quality of life in rural and isolated populations are seldom incorporated in current definitions. For the purpose of this toolkit, the following definition was used proposed: *Rural and small-town communities are those that have 10,000 or fewer residents and are situated outside commuting zones of large metropolitan areas and cities. 'Isolated' implies having limited or no road access nor ready access to specialized services.*

Consultation process

Members of the Expert Panel were selected on the basis of their involvement with primary health care and mental health care in rural and isolated areas across Canada. Strategies used in the development of the toolkit included a survey (over 30 responses received from a range of providers) and several focus groups (reaching consumers, families and caregivers, and providers and members of various associations).

Key messages

- **Numerous access issues exist** including insufficient numbers of health care professionals and resources, and travel barriers and costs created by the distance from health care professionals in urban centres. **Strategies for improving access include:** using diverse channels of communication (such as radio, television, newspaper and the Internet) to disseminate health care information; creating regional health authority sub-organizations or other bodies to help high-risk groups; developing self-help

manuals for consumers to foster health promotion and prevention; using telemedicine to overcome distance and isolation from service; and providing transportation.

- **Consumer centredness** can involve having inclusive meetings between consumers and providers; providing consumer/client advocate/complaints officers to address consumers' needs; enabling consumers to make self-referrals to mental health; and supporting transportation to mental health services outside of rural areas.
- **Policy and legislative issues reflect discrepancies** between federal and provincial jurisdictions, particularly for Aboriginal Peoples, and put limits on service delivery. There is a need to mandate core competencies for mental health care providers in rural and isolated areas.
- **Funding issues are critical**: Resources to provide basic care are not adequate, and additional funds are needed to provide financial incentives to attract health professionals. Funding is also needed to provide resources directed to consumers who need and utilize higher levels of mental health care to prevent more costly service utilization.
- **Evidence-based research is needed** to assist in better planning and service delivery for rural and isolated populations, and creativity is required to plan and support this type of research. This is required within a context of involving community members in a way that will ensure community needs are being addressed.
- **Showing success in terms of evaluation is a necessity** in creating leverage for change. Particular care needs to be taken to ensure evaluation tools are appropriate to rural and isolated populations.
- Although there are a number of 'best practice' approaches, critical to the success of rural and isolated collaborative initiatives appears to be **flexibility and local adaptations that make each effort unique**, such as two clinicians working locally, fly-in visits, or distance video conferencing. Each are attempts to bridge gaps in providing clinical service that otherwise would not be present.
- **Collaborative approaches need to consider the following:**
  - Using multidisciplinary teams which include community advisory committee members and consumers
  - Accrediting key stakeholders such as family doctors and other mental health providers to provide mental health care
  - Starting collaborative partnerships informally and involving non-clinicians (e.g., clergy, teachers, care providers)
  - Providing core training to health care professionals
  - Ensuring a network of formal and informal supports to clinicians providing primary mental health care

- **Collaborative strategies to improve effectiveness include:**
  - Enhancing the richness of the collaboration to improve overall co-ordination of services among providers and decrease the burden of care for family physicians and other first-line providers
  - Using a pyramid model of health care provision to serve a greater number of consumers more effectively, i.e., have proctors and supervisors for community health workers so that psychiatrists are not the first point of contact
  - Enabling flexibility in role assignments in order to 'get the job done'
  - Facilitating access to clinical supervision or peer supervision for 'back-up' even if this involves a long-distance relationship
  - Training in 'collaboration' for those working in the area

Introduction

- Those living in rural and isolated areas are a culturally unique and diverse population.
- Many disparities exist for those in rural and isolated areas in rates of illness, access to health care and loss of their way of life.
- Canada's Aboriginal Peoples, who constitute a large proportion of those in isolated areas, are burdened with some of the highest rates of mental illness and often have the least access to appropriate care.

Canadians residing in rural and isolated areas are not a single, homogenous group. Cultural diversity, a fundamental Canadian characteristic, is as true of rural communities as of urban (Ryan-Nicholls, 2004). While many rural communities are located in large agricultural regions, others are located close to major urban centres, are coastal communities or are located in the most remote areas of Canada's north.

Contrary to their diverse nature, rural and isolated communities share common problems in health status and in access to health care (Ryan-Nicholls 2004). Health indicators consistently reveal that significant disparities exist in health outcomes "between people who live in the northern part of Canada versus the south, and between people who live in Atlantic Canada and the rest of the country" (Commission on the Future of Health Care in Canada, 2002, p. 16). Countless rural and isolated Canadian communities encounter tremendous demographic, economic, social and ecological challenges associated with geographic isolation, depopulation and aging populations, environmental decay and depletion of natural resources.

The health of a community appears to be inversely proportional to the remoteness of its location. Most provinces and territories show a trend towards progressive deterioration in health the greater the distance from urban areas. Residents of rural health regions not only have a lower life expectancy than the national average, but they also experience higher rates of disability, violence, poisoning, suicide and accidental deaths than do their urban counterparts (Statistics Canada, 2001).

Rural and isolated residents are forced to deal with more mental and physical health issues than urban residents, however they have fewer resources to help address these problems. People in rural and isolated areas have lower levels of education and lower standards of living than urban populations. Access to allied health services and initiatives, such as nutrition services, may be inconsistent or too costly for residents in rural areas (Ogasawara, 2005). In addition, rural and isolated communities frequently have aging populations and experience youth migration to larger centres as young people search for better job opportunities.

Consequently, rural and isolated populations have an increased incidence of long-term disabilities, higher stress levels and increased risk of physical and psychological difficulties. These factors result in rural and isolated residents' shorter life expectancies and generally less healthy lives than urban residents (McIlwraith & Dyck, 2002).

When considering rural and isolated populations in Canada, it is important to look at the needs of Aboriginal Peoples. They constitute one of the largest segments of isolated populations and face severe problems as they try to recover from cultural and political oppression. Compared to the general population of Canada, Aboriginal Peoples have three times the rate of diabetes (Aboriginal Diabetes Initiative, 2000) and three to six times the rate of death by injury, including high rates of violence and suicide (Health Canada, 2001). In addition, a large percentage of Aboriginal mental health users initially receive counselling through the justice system as young offenders or adults related to traumas earlier in their lives.

> *"Residential schools damaged generations of children, resulting in the disruption of parenting skills from one generation to the next."*
>
> *Toolkit participant*

This Canadian Collaborative Mental Health Initiative (CCMHI) series of toolkits includes one specifically for initiatives involving Aboriginal Peoples. The toolkit is available on the CCMHI website, www.ccmhi.ca.

Defining the population

- There is no standardized definition of rural and isolated populations.
- The definitions that do exist neglect fundamental aspects relating to the quality of life of rural and isolated populations.
- For the purposes of this toolkit, a synthesis of several definitions of 'rural and isolated' will be used.

In Canada, defining what is meant by 'rural' has provoked debate spanning several decades (Public Health Agency of Canada, 2002). No standardized definition exists to guide research, policy, and/or planning initiatives. Traditional definitions of rural have focused on population numbers and geography. For example, Statistics Canada (1991) has defined rural as those areas which have less than 1,000 people living within a population density of less than 400 people per square kilometer. The Organisation for Economic Cooperation and Development (1994) has viewed predominantly rural regions as those with population densities of less than 150 persons per square kilometer. Definitions

within this domain focus on small numbers of people and neglect important 'qualitative' components relevant to health care providers.

Increasingly, it has been recognized that due to Canada's rich diversity, no single definition can capture the meaning of 'rural' in its entirety. Further, a broadening of 'rurality' should consider not only population density but other elements such as distance, access to services and self-perceptions (Dukeshire, 2002).

A synthesis of the varying perspectives is proposed and the following definition is offered for the purposes of this toolkit: **"Rural and small-town communities are those that have 10,000 or fewer residents and are situated outside commuting zones of large metropolitan areas and cities (Bollman, 1998). 'Isolated' implies having limited or no road access nor ready access to specialized services."**

Fundamental to these definitions are the self-perceptions of the residents of these areas - their personal values, beliefs and lifestyles as well as geography and population density.

Lessons from the literature

- There is a scarcity of literature discussing rural and isolated collaborative initiatives.
- More information is available from government statements than from research publications.
- The evidence base is a work in progress. We await more input from readers and reviewers.
- Concept articles are more numerous than in-depth studies.
- 'Rural and isolated' services are 'sparse to non-existent'.

The Expert Panel researched a variety of sources from the broad health care literature. This review showed that the literature is still sparse and lacks controlled-trial research regarding the most appropriate models of care. Many articles are policy oriented, government based or position papers from professional bodies. We have attempted to list highly relevant papers that the Expert Panel believes may hold value in key areas such as policy, needs assessment and clinical care, or that are discipline specific (medicine, psychology, etc.) in Appendix C.

For additional information on lessons from the literature consult two CCMHI reports available at www.ccmhi.ca:
- *Annotated bibliography of collaborative mental health care*
- *Better practices in collaborative mental health care: An analysis of the evidence base*

Collaborative models and initiatives

- As few as two partners are often delivering collaborative mental health care in rural and isolated areas.
- Flexible categories of models based on unique characteristics appear most appropriate, i.e., technology used, health disciplines involved or location of delivery.
- Numerous models exist, and we invite initiatives to share their work.

In most rural and isolated parts of Canada, mental health services have often arisen from hospital-based or government-sponsored support from academic centres some distance away.

There are a number of approaches that can be considered 'best practices' when dealing with

For additional information on positive practice initiatives in Canada, consult the following document available at www.ccmhi.ca:
- *Collaborative mental health care in primary health care. A review of Canadian initiatives: Volumes I and II*

rural and isolated populations. Critical to the success of rural and isolated collaborative initiatives appears to be flexibility and local adaptations that make each effort unique. Whether it be two clinicians working locally, fly-in visits or distance video conferencing, all are attempts to bridge gaps in providing clinical service that otherwise would not be present. Not all should be 'treatment based,' but as McIlwraith and Dyck (2002, p. 5) believe, "the design and implementation of empirically-based behaviour change programs aimed at enhancing personal health practices (e.g., stress management programs, smoking cessation, weight reduction)" are essential to meet the special needs of rural and isolated communities.

Other approaches that have played important roles in fostering collaborative initiatives in rural and isolated areas include clubs and support groups that provide social and educational as well as health promotion opportunities for consumers with chronic mental illness. Examples of such clubs include the *Wrap Around* youth project in Sooke, British Columbia for high-risk youth and the *Bridges* program in Gibsons, British Columbia. *Bridges* is a 14-session course, teaching consumers about medications and their side effects, tips for daily living (including money management, and shopping for their daily needs and groceries), self-management and increasing awareness of signs of relapse. *Bridges* is taught by trained consumer teachers.

Other 'best practices' that have been recommended by rural and isolated health care professionals are listed in Appendix B.

Key elements and fundamentals of collaborative mental health care

Accessibility

- There are insufficient numbers of health care professionals and resources.
- Travel barriers and costs are created by the distance from health care professionals in urban centres.
- Some programs, such as nutrition services, may have limited availability or be prohibitively costly.
- Providers need to use diverse channels of communication, such as radio, television, newspaper and the Internet, to disseminate health care information.
- Creating regional health authority sub-organizations or other bodies aimed at helping vulnerable and high-risk groups, such as children, seniors and high utilizers of mental health services, is critical.
- Developing self-help manuals for consumers will foster health promotion and prevention.
- Using telemedicine helps overcome distance and isolation from service providers.
- Providing mental health services outside of rural areas and transportation to these services will help address access issues.

People living in rural and isolated areas are confronted with significant access issues that make it difficult to receive adequate health care. One of the major issues is an insufficient number of health care professionals and resources. The Canadian Psychological Association's paper, *Strengthening Rural Health*, found that, "Between 1991 and 1996 the proportion of physicians working in rural Canada decreased, while the population increased. Mental health services are less available in rural than in urban areas" (McIlwraith & Dyck, 2002, p. 3). This scarcity of physicians is compounded by the fact that

Figure 1 Framework for collaborative mental health care

rural people have relatively less access to the health promotion, health education and illness prevention services that do exist (Jennissen, 1992).

Canadians living in rural and isolated communities also face many challenges finding appropriate mental health care. Some of these challenges include access to primary mental health care, diagnostic services and specialized treatments, as well as difficulties retaining mental health care providers. Moreover, there are limited mental health care facilities available and many of these facilities are in critical need of upgrading. As well, access to other health professionals who can participate in an individual's mental health treatment (e.g., occupational therapists, dietitians) is becoming increasingly scarce.

In addition to these serious issues, rural residents experience the extra burden of high costs incurred while traveling to obtain required mental health care. For most, this traveling necessitates days or weeks away from family and social supports, not to mention the costs for sustenance and accommodation.

Although lack of access to mental health services is definitely a major quandary, resolving this problem may not be sufficient to significantly improve the mental health status of rural residents unless new and innovative strategies are created and implemented. Some suggestions include expanding mental health promotion and education to include the broader community; and establishing congruency in policies, legislation and funding regulations.

Expansion of mental health promotion and education to encompass the broader community may include involving self-help groups and clergy in mental health promotion strategy preparation, and 'hosting' psychoeducational sessions on topics of interest (in Manitoba: ASIST (Applied Suicide Intervention Skills Training), body image awareness; in Newfoundland: presentation on managing test anxiety for grade 12 students). Nurturing trust among community providers facilitates an environment where buy-in is more likely. Such a model ideally should permit consumers to choose to see health care providers such as a nurse practitioner, physiotherapist, pharmacist or dietitian, decreasing the need for referral by a physician. Since collaborative mental health care has multiple points of access, it can serve a greater number of consumers more effectively.

The shortage of health care professionals has also led to the "inappropriate use of physicians for the treatment of psychological issues . . . in rural areas, where physicians are already in limited supply and, consequently, often over-worked. Taken together, these circumstances create an environment where early detection and treatment is unlikely and pharmacological interventions are the primary means of treating mental health difficulties, family problems and stress-related conditions" (McIlwraith & Dyck, 2002, p. 4).

Steps that can be taken to address access issues for rural and isolated populations include using telemedicine to overcome the scarcity of health care professionals and to reduce problems caused by distance from health care centres. Providing transportation and travel cost reimbursement to those seeking mental health services outside of rural areas will also improve the availability of health care.

Creating regional health authority sub-organizations or other bodies aimed at helping vulnerable and high-risk groups including children, seniors and high utilizers of mental health services, will help ensure that all members of rural and isolated communities receive the care they need. Providing mental health services in the same place as primary health care is received will enhance confidentiality and decrease the stigma attached to receiving mental health care. Finally, facilitating access to health promotion, education and prevention can be achieved by employing diverse channels of communication, such as radio, television, video, DVD, newspaper and the Internet, to disseminate health care information as well as developing self-help manuals for consumers.

Collaborative structures

- Collaborative multidisciplinary teams should consider including community advisory committee members and consumers.
- Key stakeholders, such as family doctors and other mental health providers, should be accredited to provide mental health care.
- Collaborative partnerships in rural and isolated areas often start informally and involve non-clinicians (e.g., clergy, teachers, care providers).
- Core training of health care professionals is needed to address the decline in the standardization of education.
- A network of formal and informal supports is critical to supporting clinicians providing primary mental health care.

When considering the determinants of health, health services have limited influence on a person's capacity to achieve health (Alberta Association of Registered Nurses, 2003). However, the focus is all too often on treatment when an individual presents for care. To enhance the capacity of rural residents to achieve optimum mental health, mental health promotion practices must be adopted and implemented. Further, existing key stakeholders, such as family physicians and other health care professionals, should be accredited to provide mental health care. Moreover, to offset the decline in the standardization of mental health promotion education, core training and education of health care professionals must be established.

Within the collaborative mental health care model, it is anticipated that the establishment of formal and informal partnerships among community agencies and resources will support the integration of services across the various sectors that influence the mental

health of rural residents. Provision of appropriate and timely care for rural mental health consumers requires not only collaboration with other sectors, such as justice, labour, social services, mental health, housing and education, but also multidisciplinary needs assessment teams that include allied health professionals, community advisory committee members and consumers. Teamwork requires the efficient use of members' time and should ensure practical, measurable goals are determined. Establishing smooth referral mechanisms among such professionals and agencies can have a valuable impact on the mental health of rural residents and their families.

Richness of collaboration

- Improving co-ordination of services with other providers will decrease the burden on family physicians and other first-line providers.
- Using a pyramid model of health care provision will serve a greater number of consumers more effectively, i.e., have proctors and supervisors for community health workers so that psychiatrists are not the first point of contact.
- Flexibility in role assignments is often required to 'get the job done'.
- Access to clinical supervision or peer supervision for 'backup' is key, even if this involves going outside of the geographical area.
- Training in collaboration for those working in the area is an effective approach.

> *"In Twillingate, a natural team developed for the long-term care unit."*
>
> *Toolkit participant*

> *"Collaboration requires a shared need or issue."*
>
> *Toolkit participant*

Co-operation between health care providers has been a challenge, and this is no different for those working in rural and isolated areas. Unique to this population, however, is how a focus on 'doing what works' is often applied to creatively work towards improved services. Still, issues include a current rural and remote health care system that is over-reliant on a shrinking number of family physicians. Interprofessional collaboration would encourage optimum co-ordination of existing primary health care providers to ensure increased access to the skills and competencies that a range of health care professionals has to offer. Moreover, such co-ordination would ensure that all providers are functioning within their full scope of practice. Interprofessional collaboration will function best if participation is voluntary and there is a well-defined shared purpose or focus.

Further strategies to enhance collaboration include boosting morale through adequate compensation for increased travel, providing portable service delivery and offering

'outreach services' in locations where mental health care is not often available. Avoiding repeat assessments and inefficient use of expensive expertise by having front-line staff undertake as much of the initial assessment as possible and improving communication are also essential in any clinical setting.

Consumer centredness

- Have inclusive meetings between consumers and providers.
- Provide consumer/advocate complaints officers to address consumers' needs.
- Consumers should be able to make self-referrals to mental health services.
- Mental health services outside of rural areas, and transportation to these services, should be available to consumers.

> *"Although rural/isolated clients may be more likely to engage with service providers who are not in their local community (i.e., privacy and confidentiality, dual relationship issues), these service providers **must**, **must**, **must**, be willing to take the time to develop collaborative relationships over time (and to maintain these relationships) otherwise local service providers may be reluctant to work with these 'outside' service providers."*
>
> *Toolkit participant*

For a rural and isolated area, a consumer-centred approach creates opportunities for mental health consumers and their families to have 'a voice', thereby providing opportunities for increased participation of consumers and families in all decision-making processes surrounding mental health care provision. Increase in availability or access to mental health services will lack effectiveness if mental health consumers are not sufficiently comfortable to fully and effectively participate in mental health promotion activities. Help-seeking and collaboration are deterred by the fact that anonymity is impossible because 'everyone knows everyone'. Primary health care providers must earn the trust of a community to overcome this situation.

Primary health care providers must also work through the following dilemma:

> *"…recruitment of mental health providers increases access for clients but proximity results in a fishbowl effect which impedes the development of boundaries and the development of the therapeutic alliance, especially when the provider is an active*

> *member of the community; professionals need a unique type of support on these issues."*
>
> *Toolkit participant*

Anonymity and confidentiality may be achieved by the presence of a co-located primary health clinic to enhance privacy (i.e., professional visit is not obviously for mental illness).

Increased levels of comfort can also be realized if the stigma surrounding mental illness is reduced. Strategies for stigma reduction include provision of information about, and normalization of, common symptoms and issues experienced by consumers at the time of initial contacts with family physicians (where most mental health needs are first discussed); brief, 5-minute psychoeducation sessions to empower consumers to be more actively involved in their care; and follow-up phone consultations with consumers (to reduce need for transportation). Inclusive meetings between mental health consumers, families and health care professionals can facilitate the achievement of consumer-centred goals. A consumer advocate/complaints officer could be appointed to address consumer and/or family needs/concerns that may conflict with health care providers.

Policies, legislation and regulations

- Collaborative initiatives are hindered by policy and jurisdictional impediments and restrictive program mandates such as the lack of educational standards for health care teams or insufficient support for rural student teaching.
- Short-term 'pilot' project funding prevents the building of collaborative relationships for care team members.
- Age limits for Ministry of Health involvement (i.e., 16 and above) restrict children's access to mental health care.
- Federal jurisdiction over services for Aboriginal Peoples results in complex processes for services; uncertainty regarding who will be served within provincial jurisdiction; barriers for Aboriginal Peoples who live off of reserves (e.g., transportation).
- Provincial mandates for 'core competency' training have been lost.
- There is no mandated health and mental promotion programming to reduce costs in the long run.
- Strategic plans for primary health care services do exist in some provinces.
- There have been attempts to try to address unmet need via primary health initiatives based on local needs; some needs assessment is being done ***prior*** to implementation of services.
- Providers need freedom to work and collaborate in unique ways.
- Need to build ability of available service providers to provide flexible services, have broad-based training.

> *"My biggest dream would be that people throw the jurisdictional issues out of the window. Basically the province, the health authorities, the feds, and the bands need to get together and stop working in silos and work together to assist this population [Aboriginal Peoples] with their mental health…"*
>
> *Toolkit participant*

The development of collaborative initiatives in rural and isolated areas is hindered by variable policy interpretation, jurisdictional impediments and restrictive program mandates, including a lack of educational standards for care teams and insufficient institutional support for rural student teaching. These initiatives are also inhibited by the fact that there is no mandated health and mental health promotion to reduce costs in the long run nor short-term 'pilot' project funding that would build collaborative relationships for health care team members.

Some of the barriers to mental health promotion identified by respondents surveyed as part of the consultation process for this toolkit (see Appendix A) include lack of ***mandated*** supervision time for future practitioners (regarding broad-based training and preparedness), lack of satellite training facilities and lack of postgraduate support. Survey participants also responded that there are insufficient monetary incentives to attract and retain health care providers in more isolated areas, particularly (as noted by the University of Manitoba rural training psychology internship program) early in the training process.

A number of respondents also recommended that provincial policies mandate core competencies for mental health care providers in rural and isolated areas. A health care professional in Manitoba describes the dangers of the lack of standardized training:

> *"The regionalization of Manitoba annihilated education for mental health care workers. When I went to [..] eight years ago… I needed to complete the core modules which covered everything from pharmacology to community development programs, . . . with the splitting of Manitoba Health into regions this particular education standard is no longer in place so you just hope like hell that the person being hired is going to have the qualifications and be able to carry out the performance which is required within the community health positions."*
>
> *Toolkit participant*

Developing collaborative initiatives to serve Aboriginal Peoples is particularly challenging because they fall under federal jurisdiction. The federal government has developed complicated and convoluted processes that consumers are forced to navigate in order to obtain services. The situation is further compounded by confusion over whether provincial or federal governments are mandated to serve the health care needs of Aboriginal Peoples living off of reserves.

Despite these hurdles, there are some situations where policies, legislation and regulations facilitate collaborative mental health care initiatives including the existence of strategic plans for primary health care services in some provinces. There are also attempts to try to address unmet needs via primary health care initiatives based on local needs. Some have included needs assessments done prior to the implementation of services. See Appendix B for descriptions of positive practice initiatives.

Consideration should be given to creating congruent policies and legislation in rural and isolated areas to allow health care professionals the freedom to work and collaborate in unique ways. Respondents to the survey conducted as part of the consultation process for this toolkit (see Appendix A) reported that many service providers offer flexible services and have broad-based training that prove useful in creating collaborative initiatives.

In spite of the increased understanding that rural health problems are unlikely to be adequately addressed by mainstream programs alone (Humphreys et al, 2002), many health care planners, providers and administrators continue to rely solely on the use of urban-focused approaches rather than designing models to suit the unique circumstances of rural communities. Continued reliance upon the use of urban models will create barriers for rural and remote communities in their efforts to achieve equal status with their urban counterparts.

Funding

- Financial incentives are necessary to attract and retain health care professionals.
- Funding pools specifically for mental health should be separate from physical health and hospital funding.
- Permanent mandated collaborative initiatives and financial sharing should be instituted.
- Financial resources should be directed to providing services to consumers with higher levels of need to prevent costlier service utilization.
- Permanent financial support for employment and recreational funding is a necessity.
- Funding for youth services is critical.
- Funding for mental health promotion activities and staff should be provided.

"The extremely limited number of publicly funded psychologists and the exclusion of psychological services from medicare funding further hamper access in rural areas. In spite of this, psychological services outnumber psychiatric services in rural Canada." (McIlwraith & Dyck, 2002, p. 3)

Funding to support rural and isolated collaborative mental health care initiatives needs to consider both funding structures and resources. In terms of funding structures, money for mental health services needs to be protected by separating it from other funding pools, such as hospital and physical health budgets, otherwise mental health will continue to be chronically underfunded.

> *"Big expensive primary health centres end up being subsidized by the best practice, least intrusive, closest home kinds of interventions that end up drying up mental health. If mental health continues to be funded through the same source as the one that funds the primary care health and hospital, we are going to continue to be under-funded because those are the ones that are going to run the deficits and the funds will go to places that make themselves heard. Mental health historically and currently is well recognized as marginalized and often overlooked."*
>
> *Toolkit participant*

There also needs to be substantially more funding for mental health care including permanent, mandated primary care collaborative initiatives and financial sharing. Moreover, funding should be directed to provide services to consumers with higher levels of need to prevent costlier service utilization. This would include funding for services for children, seniors, consumers with chronic mental health problems, and couples and families. Permanent financial support for employment and recreation programs and flexibility in funding to remunerate indirect care would also be beneficial to rural and isolated populations.

Meeting the needs of rural and isolated populations is also dependent upon attracting and retaining health care professionals. As a result, it is important to establish financial incentives to attract family physicians and allied health professionals, and to encourage students to complete their training in rural and isolated communities.

Other funding priorities suggested by survey respondents include:

- Mental health prevention and promotion staff positions
- Incentives for urban specialists to support rural/isolated programs

Evidence-based research

- Tackle methodological issues, i.e., definition of rural, challenges of appropriate methods of research.
- Epidemiological issues include the need for prevalence studies.
- More local and regional 'needs assessments' required.
- Socio-cultural beliefs about mental illness are related to disparities in the use of services.
- Clarify reasons for obstacles to access, i.e., reasons for rural/urban differences.
- Further attempts to determine why suicide rates are higher in rural and isolated areas than in urban areas are required.

> *"NAPHWI - Northern and Aboriginal Population Health and Wellness Institute - is working on three particular things: diabetes, youth suicide, and traditional and spiritual healing. They are really trying to work hard with these four communities to assist them to come up with their own plans and how they can start preventing youth suicide."*
>
> *Toolkit participant*

Although the challenges associated with rural and remote health have been widely acknowledged by rural communities for some time, it is only recently that any concerted effort has begun to address these difficulties (Ryan-Nicholls, 2004). However, despite these efforts, strategies, programs and policies for improving the health status of rural residents and the sustainability of mental health care in rural communities have not been based on solid evidence or research. In the past, Canadian research on rural health issues has been piecemeal in nature and limited to small-scale projects (Commission on the Future of Health Care in Canada, 2002). To make matters worse, despite the wealth of health-related data at the federal, provincial and territorial levels, most data collected or released are not presented in a manner that supports meaningful rural health research and analysis (Pitblado et al, 1999). Furthermore, as with health research in general, there is little connection between decision-makers and researchers. Consequently, rural strategies, programs, health policies and practices have not been as effective as they might have been.

Complicating this situation is the fact that there is no single, agreed-upon definition of 'rural Canada', nor is there likely to be one in the near future. However, even without an agreed-upon definition, it is important for researchers to understand that their choice of definition should be determined by the type of data available and, in the case of secondary data, the manner in which the data were collected and entered into databases.

Although the research findings may be statistically robust for differing definitions of rural, in many instances, the research results will vary in accordance with the definition that was first decided upon. Ultimately, it is imperative that researchers recognize that the definition of 'rural' and the method for determining it should be "tailored to the task at hand" (Halfacree, 1993).

A paucity of literature exists documenting the accessibility, availability and appropriateness of mental health service delivery in rural areas. Information that is available suggests that rural environments are less likely to have these services and, if they do, the range of such services is narrow (Shelton & Frank, 1995). A significant barrier to services in many rural and remote areas is geographical isolation from the centres where mental health care services are available (Ryan-Nicholls et al, 2003).

Research is clearly a 'hot-button' priority topic for many of our respondents. The suggestions provided here are specific and intended to assist in planning and influencing key clinical areas as further services are developed.

Community needs

- Information displays, health services and screening sessions (for depression, anxiety and other issues) should be provided in malls, schools and other community locations.
- Walk-in mental health services could be established.
- Non-physicians referring patients to mental health services may decrease delay for services.
- Consumers would benefit if able to make self-referrals to mental health services.
- Supportive housing and employment and respite help are lacking.
- More self-help and community development groups for children and seniors are needed, such as Community Kitchens programs.
- Advertisement of local services and information through the Internet, radio and local television regarding dealing with common mental health problems and promoting day-to-day healthy living should be pursued.
- Inclusion of key community members on advisory committees for primary health and other mental health initiatives is important.

> *"As a family member, I know the value of respite care . . . This needs to be made available to all caregivers. Family members who are caring for their mentally ill relatives at home report the haphazard outreach, if any, to their relatives. As there never*

> *seem to be enough outreach hours available, these clients seem expendable, making the burden heavier for family members."*
>
> *Toolkit participant*

To meet community needs, community members must be involved in the development and delivery of collaborative mental health care. Having key community members and community elders on advisory committees for collaborative mental health care initiatives will foster community support and reduce the stigma attached to receiving mental health services. Community focus groups are another useful way to ensure that community needs are being addressed.

There are a number of strategies that can be used to work with the community to meet rural and isolated needs. They range from providing supportive housing and employment to allowing consumers to make self-referrals to mental health services. More self-help and community development groups for children, seniors and others in need will foster healthier communities. Building awareness of mental health services through advertising and information on the Internet, radio and local television will also help deal with common mental health issues and promote day-to-day healthy living.

Other effective ways of meeting community needs include offering mental and primary health care services at the same location to protect consumers' confidentiality, establishing walk-in mental health services and allowing non- physicians to refer consumers to mental health services. Providing information displays, health services, and screening sessions (for depression, anxiety, and other issues) in malls, schools and other community locations will further improve the access of all community members to mental health services.

Planning and implementation

- Be creative in planning to permit a degree of freedom to work and collaborate in unique ways.
- Take a community development approach to mobilize local participants in the process.
- Allow service providers to provide flexible services.
- Ensure clinicians have broad-based training.
- Include key community members on advisory committees for primary health care and other mental health initiatives.
- Consider integration with early intervention/monitoring initiatives.
- More proctors and peer supervision for front-line staff are needed.
- Facilitate team building.
- Give clear consideration to confidentiality issues.

> *"When students are out in the rural or remote areas doing clinical [work] there isn't sufficient support from the educational facility, sometimes they are just left out in the environment floundering with an overburdened nursing workforce and often are at a loss as to how to proceed."*
>
> *Toolkit participant*

> *"We need to identify some projects that are vehicles for collaboration and do it!"*
>
> *Toolkit participant*

Any start-up service requires broad dialogue, an effective model or concept to guide services and key community 'champions' to lead efforts to implement it. Some considerations are provided in addition to what is given in the CCMHI General Toolkit, *Collaboration between mental health and primary care services. A planning and implementation toolkit for health care providers and planners* (Kates et al, 2006).

Mandated supervision time for future practitioners, satellite training facilities, post-graduate support and building on the existing strengths of health care teams and services are all supports for rural and isolated communities. Collaborative mental health care teams focused on prevention, health promotion, rehabilitation, assessment, treatment and monitoring are another practice focus encouraged in the survey conducted as part of the consultation process for this toolkit (see Appendix A).

Obstacles to recruiting and retaining health care professionals may mean that communities should consider appealing for more federal and provincial funding to increase the number of mental health care workers. Financial incentives to attract both professionals and students to rural and isolated areas may also need to be investigated in building collaborative mental health care initiatives in these communities.

McIlwraith and Dyck (2002) recommend making a commitment to health care professionals working in rural and remote areas through increased networking opportunities, access to continuing education, specialist consultation, peer support and expedited referrals to tertiary centres when needed. Retaining qualified and committed staff also depends upon encouraging people from rural and isolated areas to enter health care professions.

Unique systems, structures, processes and protocols suggested by survey respondents include:

- Additional travel and meal allowances for traveling staff
- Additional support time and the promotion of ongoing staff education to prevent burn-out/isolation and support retention
- Co-location of services for better communication
- Facilitation teams to assist in establishing and maintaining collaborative relationships
- Close relationships between inpatient services, community and other partners to create a more 'equal, horizontal approach'
- Facilitation of team building and retention
- Making services outside of rural areas and transportation to these services available
- The use of local media; promoting community volunteerism to keep costs down, build community and provide opportunities for meaningful consumer involvement

Unique qualities or skills of value in rural and isolated settings:

- Consider a broad range of staff from income assistance, housing, nursing and psychology to medicine, psychiatry, dietetics, pharmacy, rehabilitation, probation/young offender staff, and assistance from university staff to promote best practices and statistical/evaluative/policy strategies at provincial level.
- Include First Nations councils and Aboriginal groups.
- Encourage cross-cultural training.
- Utilizing local community paraprofessionals is also essential (e.g., church groups, etc.)
- Limit language barriers by promoting fluency in languages spoken locally.
- Build on the existing strengths of health care teams and services.
- Create clubs or support groups that provide social and educational opportunities as well as health promotion activities for consumers, e.g., individuals with chronic mental illness.
- Establish collaborative teams focused on prevention, health promotion, rehabilitation, assessment, treatment and monitoring that meet regularly.

Evaluation

- Showing success is a necessity in creating leverage for change, so measure what you do, or what is being done, and its impact.
- Consider both quantitative ('how much') and qualitative ('how come') aspects of program functioning.
- The impact of primary health care/mental health care initiatives can be evaluated with quality-of-life measures, consumer and provider satisfaction, analysis of cost effectiveness, changes in average service utilization within specific years, validated measures of symptom severity and symptom checklists.
- Assessment, monitoring and evaluation tools are not consistently used because there are different needs for different populations, however, there is a need for mandated time- and cost-effective tools relevant to rural and isolated populations.
- Measure what matters – each initiative will have its own priorities and thus evaluate different components.
- Evaluation is ever changing – as the questions one asks change, so too will the components being evaluated.
- Consider literacy rates and preferred language when choosing measures.
- Front-line workers considered effective 'screening tools' very valuable.

Specific outcomes relevant to rural and isolated populations

> *"One would want to evaluate the partnership itself from both the perspective of the partners and from that of the external stakeholders who are using collaborative services. Ultimately, quality-of-life measurements of the service recipients are critical to the evaluation."*
>
> *Toolkit participant*

The success of collaborative mental health care initiatives in rural and isolated populations should be assessed using both qualitative and quantitative data. Many rural and isolated health care providers have stressed the importance of developing standardized and comprehensive quality improvement measures. The Continuous Enhancement of Quality Measurement in Primary Mental Health Care: Closing the Implementation Loop project is developing a series of tools to support quality improvement in primary mental health care services. For more information, please see their website at http://www.mheccu.ubc.ca/ceqm/index.cfm.

Key indicators that a collaborative initiative is relevant to a rural and isolated community include a reduction in wait times to see primary or mental health care providers, lower

hospital re-admission rates for mental illness and increased consumer satisfaction with services as well as improvement in consumers' quality-of-life satisfaction ratings. Looking at these indicators allows health care providers to assess whether or not consumers are receiving the right services and determine if their specific needs are being met.

Consumer (and consumer advocacy group) involvement in developing and evaluating collaborative mental health care initiatives is essential to their success. The views and opinions of consumers should be sought through focus groups and surveys in addition to involving them as active members on collaborative mental health care initiative teams.

Recommended tools or measures specific to rural and isolated populations

Rural and isolated health care providers use a range of assessment and diagnostic tools to evaluate the mental health of consumers. The majority of tools were not developed specifically for rural and isolated populations, however, they play an important role in evaluating these populations.

Commonly employed tools or measures are:

- BASIS 32 (Behavior and Symptom Identification Scale)
- BCFPI (Brief Child Family Phone Interview)
- Beck Depression Inventory
- CAFAS (Child and Adolescent Functional Assessment Scale)
- Conners' Rating Scales
- DATIS (Drug and Alcohol Treatment Information System)
- Inter-R-A-I (Resident Assessment Instrument) mental health and addiction screener
- Psychosocial Rehabilitation Toolkit
- SASSI (Substance Abuse Screen Inventory)
- SOCRATES (Stages of Change Readiness and Treatment Eagerness Scale)
- Suicide risk assessments
- Symptom Checklist-90
- TAPPC (The Arson Prevention Program for Children)
- WHO-DAS (World Health Organization-disability assessment survey)

The use of these tools varies according to what particular health care providers deem beneficial as well as affordable. Some providers see this as a positive situation. A Manitoba mental health worker, for example, says that evaluation is helpful… "if it applies and if it is appropriate." In contrast, some health care professionals express concern and frustration that there is no standardized approach for evaluating mental health. Moreover, the need for the development of culturally specific assessment tools and forms that are more responsive to particular communities, such as the need for health forms relevant to Aboriginal Peoples, is another common concern among rural and isolated mental health workers.

There are some instances where health care professionals have developed tools tailored to their population. Examples include Dilico's Suicide Prevention Protocol, used in northwestern Ontario, and a community assessment and evaluation tool used in Saskatoon that was developed for their use by the Primary Health Services Branch of Saskatchewan Health. Another Saskatchewan health care professional reveals that, "The indicators that we use are site or community specific. For example, one site in Saskatoon has indicators more geared to a lower economic status, high-risk community (i.e., diabetes, asthma, smoking, immunization and physical activity)." Nonetheless, these examples of tools aimed specifically at rural and isolated populations seem to be in the minority.

Unique barriers to evaluating rural and isolated collaborative initiatives

Barriers do exist that make it difficult to evaluate the success of collaborative initiatives in rural and isolated areas. In non-urban areas, English is often not the native language which creates significant communication barriers that are compounded by the lower levels of literacy in rural and isolated areas. Both these factors can make evaluating initiatives difficult. The stigma attached to mental health care and the lack of confidentiality in smaller communities also pose challenges to evaluation because it can be hard to secure consumer co-operation. Moreover, the underfunding of mental health care means that there are insufficient numbers of mental health care professionals with training in performance measures and indicators as well as screening processes. A mental health worker in Dauphin, Manitoba is one of several health care professionals who reported that they are too busy doing front-line work to get assessment training.

The chart below, developed by the Rural and Isolated Expert Panel, summarizes some of the main issues involved in the provision of collaborative mental health care in rural and isolated communities.

Providing effective collaborative mental health care in rural and isolated areas

Challenges	Key questions	Principles
Services are often inadequate and insufficient. The mental health needs of those in rural and isolated areas are often unique and not met by usual service provision.	Have efforts been made to determine met or unmet need? What links with other regions have been initiated to determine need, guide policy or planning in their local rural or isolated area? Who could be approached to aid in planning or strategy for action?	Be realistic in goals of services: Some is often better than none.
Adds to problem of		
Insufficient numbers of qualified mental health providers. Low recruitment and retention rates. Disparity between rural and urban settings striking.	Who is providing local mental health services, formally and informally? Which primary care providers/family physicians are most likely to be points of first contact? Have efforts been put in place to address recruitment, retention or remuneration?	Training the trainer is essential since funding is project based and staff turnover is high.
Leads to		
Those obtaining care require unique solutions involving more dependence on primary care/family physician, long travel distances, technology (telemedicine).	How is care delivered locally? Who are the primary care providers- physicians, psychologists, social workers, nurses, pharmacists? What training challenges do they confront? What barriers to cooperation do they face? Do those seeking services often drive? Do any use video-conferencing? What barriers exist for special groups such as children and seniors?	Rural interprofessional training is a must. Systematic interprofessional training must begin early and be sustained through permanent continuing education. Professional development programs must accommodate clinicians' busy schedules. Interprofessional collaboration will work better if participation is voluntary and there is a narrow, well-defined shared purpose or focus. Need to improve access to workable, cheap, simple technology. (Low-tech may be a more elegant solution.)

Challenges	Key questions	Principles
A culture is created		
Unique solutions required informal supports and "safety net' involving, for example, primary care, community agencies, faith groups, agricultural, Aboriginal, law enforcement, pharmacists, key employers, etc. Such support, while valued and essential, can be stagnant and not advance as treatment progresses. Also, help seeking and collaboration may be deterred by fact that anonymity is impossible and 'everyone knows everyone'.	Which non-health care providers are/may be involved locally – police, clergy, schools, businesses, band offices, other community agencies? How may leaders in each of these help to create a safety net? What limitations do such providers confront or state could aid their work? How are confidentiality and privacy	Wider community should be involved in health promotion and training. The trust of the community must be earned. Privacy issues must be clearly managed particularly in team-based care provision.
New models are sought		
Need for new models to emerge that highlight integration and collaboration. Improve relationships with urban specialists.	Have other similar communities developed successful collaborative models? Are there programs that might be willing to offer help (check shared care or CCMHI websites)? How can you match with the type of professionals available in your area?	Approach to care best if broad, appropriate and comprehensive where possible. 'Of necessity' rural mental health must be delivered in primary care setting. Use practice guidelines, if available Need formalized relationship with urban specialists.
New models require proof		
Research, monitoring and evaluation of new initiative necessary to ensure needs are better met, and that policy and health care change are delivered.	What type of evaluation would be a priority in your area? Does your nearest teaching centre have faculty that could help with evaluation? Is mentoring available from other initiatives in larger centres? Who might share simple evaluation methods with you?	Clarify further research areas

Key issues for consideration

Definition

Rural and small-town communities are those that have 10,000 or fewer residents and are situated outside commuting zones of large metropolitan areas and cities (Bollman, 1998). 'Isolated' implies having limited to no road access nor ready access to specialized services.

Access to mental health services

Canadians living in rural and remote communities face many challenges associated with access to mental health care including:

- Difficulties associated with access to primary mental health care, diagnostic services and specialized treatments
- Challenges to retention of mental health care providers including allied health professionals
- Mental health care facilities that are limited in number and in critical need of upgrading.

Rural residents experience the extra burden associated with high costs incurred while traveling in order to obtain required mental health care. For most, this traveling necessitates days or weeks away from family and social support, not to mention the costs incurred for sustenance and accommodation.

Although lack of access to mental health services is definitely a serious quandary, resolving these issues may not be sufficient to significantly improve the mental health status of rural residents unless new and innovative strategies are created and implemented. Some suggestions include:

- Expanding mental health promotion and education to include the broader community
- Establishing congruency in policies, legislation and funding regulations.

Policy issues

Some provinces DO have strategic plans for primary health care services although mental health is not addressed adequately. Examples of positive practices include integrating family medicine and mental health in Humboldt, SK (see Appendix B for description) and NORTH Network telepsychiatry (Ontario). Other attempts are being made to try to address unmet needs via primary health care initiatives based on local needs. Some have included needs assessments done prior to implementation of services (see Appendix B for descriptions of positive practice initiatives).

In spite of the increased understanding that rural health problems are unlikely to be adequately addressed by mainstream programs alone (Humphreys et al, 2002), many health care planners, providers and administrators continue to rely solely on the use of

urban-focused approaches rather than designing models to suit the unique circumstances of rural communities. Continued reliance upon the use of urban models will create barriers for rural and remote communities in their efforts to achieve equal status with their urban counterparts.

Funding issues

Some suggested funding priorities are:

- Funding for mental health education and promotion staff positions
- Different funding pool (separate from physical health, hospital funding) specifically for ***mental health*** (i.e., priorities ***need*** to be mental health)
- Funding for elimination of barriers to specialists
- Mandated collaborative initiatives and financial sharing made ***permanent***
- Financial resources directed to providing services to consumers with higher levels of need to prevent more costly service utilization.
- ***Permanent*** financial support for employment and recreational programming
- More support and financial incentives for mental health care providers and allied health professionals to collaborate with family physicians, who typically provide most mental health services in rural/isolated areas

Summary points

1. Wider community should be involved in health promotion and training.
2. Rural interprofessional training is a must:
   a) Systematic interprofessional training must begin early and be sustained through permanent continuing education.
   b) Programs must accommodate health care providers' time constraints.
3. Help seeking and collaboration are deterred by the fact that anonymity is impossible and 'everyone knows everyone'. Providers must earn the trust of the community.
4. Interprofessional collaboration will work better if participation is voluntary and there is a narrow, well-defined shared purpose or focus.
5. To address the issue of sustainability, 'training the trainer' is essential since funding is project based and staff turnover is high.
6. Need to improve access to workable, cheap and simple technology (low-tech may be a more elegant solution).
7. Need formalized relationship with urban specialists.

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Appendix A: Consultation process

- Expert Panel included various disciplines.
- The views of individuals from across Canada were sought to develop key insights for the toolkit.
- Written and face-to-face input and opinions were gathered from government, professional bodies, consumers and consumer/advocacy groups, doctors, nurses, psychologists, psychiatrists, pharmacists, social workers, dietitians, community case workers, Aboriginal organizations and many others.

The Rural and Isolated Expert Panel was formed in February 2005 and its progress was supervised by the Panel's Lead, Dr. Jack Haggarty, with the assistance of the Panel's Project Co-ordinator.

Expert Panel members were chosen from a broad range of disciplines in the mental and primary health care fields to ensure that the views of key stakeholders would be reflected. Group members were also selected on the basis of their involvement with health care in rural and isolated areas. Consequently, the Rural and Isolated Expert Panel encompasses diverse geographic regions.

The following disciplines and geographic areas are represented in the Rural and Isolated Expert Panel:

- Psychiatrist (Northwestern Ontario)
- Family physician (British Columbia)
- Psychologist (Newfoundland)
- Registered psychiatric nurse and Assistant Professor (Manitoba)
- Psychologist (Saskatchewan)
- Social worker (Northwestern Ontario)
- Pharmacist (Alberta)
- Primary care evaluation and service co-ordinator (Northeastern Ontario)

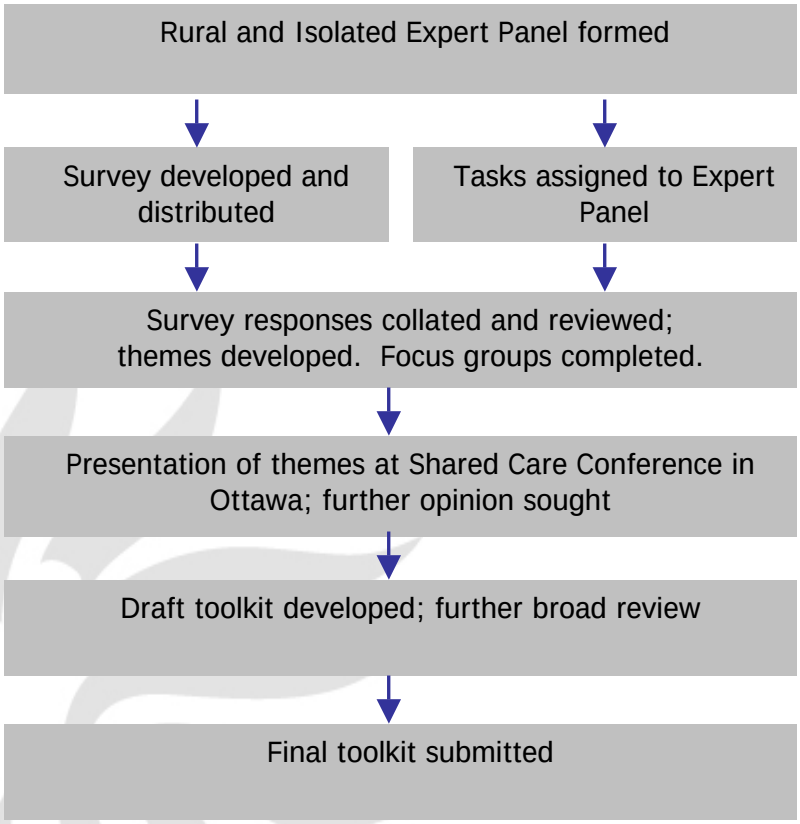
Expert Panel members held monthly to bi-monthly phone meetings. Upon review of the assignment to develop a toolkit and obtain opinions from a broad range of providers and consumers, a survey questionnaire was developed to gather the necessary input. See below for a list of the organizations and professional bodies that were sent the survey; over 30 responses were received. In addition, two focus group discussions provided valuable comments and direction.

In several locations, a focus group discussion was conducted by phone or in person. One session was recorded and transcribed. The constraints of this initiative and toolkit made an exhaustive survey of rural and isolated regions impossible. A valiant and successful

effort by members of the Expert Panel and the Toolkit Working Group to engage those within our 'network grasp' resulted in the opinions expressed here.

Responses provided by the surveys and interviews have guided the document throughout its evolution. Despite our obstacles, many rural and isolated regions of Canada were contacted and invited to participate including the Western, Central and Atlantic regions as well as the far north (see below). Detailed survey responses or interviews were obtained in all but the Arctic (see also Aboriginal Peoples toolkit available at www.ccmhi.ca). Government reports were obtained for citation. Further, consumer and family input was gathered with permission through participation in focus group discussions, survey responses, or direct feedback to Expert Panel members. Several survey responses were received from those presently obtaining mental health services, those in patient/consumer advocacy groups and national consumer-oriented organizations. While the dialogue was broad, the Expert Panel recognizes that the views obtained and presented here are not exhaustive nor reflective of the depth of all opinions obtained or collected.

The figure below summarizes the consultation process.



The following individuals and organizations were contacted as part of the consultation process:

- Assiniboine Regional Health Authority
- B.C. College of Family Physicians
- Burntwood Regional Health Authority, Thompson, Manitoba
- Canadian Association of Chain Drug Stores
- Canadian Mental Health Association
- Canadian Mental Health Association, Thunder Bay
- Canadian Pharmacists Association
- Canadian Psychiatric Association
- Canadian Psychological Association
- Chronic Mental Illness Drop In Centre
- College of Family Physicians of Canada
- Community Mental Health, Neepawa, Manitoba
- Counsellors in Goose Bay, Labrador
- Dilico Ojibway Child and Family Services in Armstrong, Longlac, Nipigon, and Mobert, Ontatio
- Family members of mental health consumer in Gibsons, British Columbia
- Family physician, Hanover, Ontario
- Family physician, Newfoundland
- Humboldt Clinic, Humboldt, Saskatchewan
- Marathon Family Practice
- Mental health consumer in Vernon, British Columbia
- Mental health workers, Parkland Regional Health Authority Services, Dauphin, Manitoba
- Mental Illness Support Network (MISN)
- People Advocating for Change through Empowerment Inc. (PACE) – Geraldton, Schreiber, Manitouwadge, Marathon, Thunder Bay, Ontario
- Prince George Northern Health
- St. Thomas Psychiatric Hospital
- Saskatoon Health Region
- Schizophrenia Society of Canada
- UBC Department of Family Medicine
- Yellowknife General Hospital (Psychiatric Unit) (Rural Site Training Program)

Appendix B: Positive practice initiatives

The Humboldt Medical Clinic

For additional information on positive practice initiatives in Canada, consult the following document available at www.ccmhi.ca:

- *Collaborative mental health care in primary health care. A review of Canadian initiatives: Volumes I and II*

This clinic serves approximately 30-35,000 persons (all age groups) from Humboldt, Saskatchewan and surrounding areas. Currently, the clinic has seven full-time family physicians, one full-time surgeon, partial laboratory services (e.g., urinalysis), and a pharmacy attached to the clinic. The Humboldt Medical Clinic family physicians also provide part-time (either once or twice weekly) service delivery to five smaller communities. The clinic's recruitment goals are 11 full-time family medicine practitioners (two of whom will provide anesthesia services), one full-time anesthetist, and two surgeons.

As part of developing primary health care initiatives to address overlapping physical and mental health issues, the Saskatoon Health Region (SHR) recruited two psychologists in 2003 to begin working collaboratively with family physicians twice monthly at the Humboldt Medical Clinic. Unfortunately, due to retention issues in the community of Saskatoon, one psychologist had to cease providing these services in April 2004.

Consumers are referred directly from one of Humboldt's family physicians. Psychological services are provided to consumers within the clinic. Owing to heightened privacy/confidentiality issues within rural settings, all psychological treatment sessions provided at the clinic are individual, couple, parent/child, or family in nature (i.e., no group sessions).

For efficient psychological service provision, initial sessions involve intake, clarification of diagnostic/problematic issues, psychoeducational information provision and initial behavioural/cognitive interventions (individualized inter-session behavioural plans are usually provided in writing for consumers). Whenever possible, this is usually followed by a brief verbal consultation with the referring family physician.

Most consumers receive brief (usually one to four sessions), very focused therapeutic interventions. Consumers who are deemed to require longer-term services are redirected to local mental health service providers. In these cases, the psychologist provides either direct or telephone consultation to these service providers. Thus far, only four individuals have refused to be redirected to local mental health service providers, citing confidentiality and/or dual relationship concerns as reasons.

Between January and December 2004, there were a total of 25 adults, 2 seniors, 4 adolescents and 10 children (35% children/adolescents, 65% adults) who received

psychological services. From January until March 2005, 6 adults, 2 adolescents and 3 children (45% children/adolescents, 55% adults) were seen, plus follow-up sessions with consumers previously seen. Identified problem areas among adults/seniors included mild to moderate symptoms of depression, anxiety, physical health (e.g., pain, adjustment to injuries, sexual functioning, etc.), mental health symptom management, balancing relationships/roles (e.g., marital, parenting) and some post-traumatic issues. Among children and adolescents, elimination/somatic issues, depression/anxiety symptomatology, disruptive/oppositional behaviour, academic concerns, peer- and sibling-related issues and sexual development/orientation issues presented.

Future goals of the collaboration will include an evaluation by both consumers and family physicians of psychological service provision. Collected data will be used for further case planning. Finally, future expansion of existing clinically collaborative services will be discussed.

Parkland Mental Health Advisory Council

The Parkland Regional Health Authority (RHA) is responsible for the planning, co-ordination, funding and delivery of all health services for the residents of the Parkland Region, situated in West Central Manitoba, Canada. Within the Parkland Region, stakeholder involvement is facilitated through the Mental Health Advisory Council. The Council includes mental health consumers, family groups, consumer groups and persons interested in mental health. Collaborative activities include the following:

- The RHA holds meetings in which community members are invited to participate. These meetings are publicized in the local newspaper and in a special newspaper called the *Community Link*. Editions of the *Link* highlight a particular issue, (e.g., diabetes); the RHA plans to dedicate an upcoming edition of the *Link* to mental health.
- The RHA funds not-for-profit organizations such as the Schizophrenia Society. Stakeholders are invited to participate in the accreditation and continuous quality improvement committees. The RHA sends surveys and questionnaires to committee members regarding their satisfaction with services and suggested areas of improvement. The RHA has a consumer/client advocate or complaints officer to investigate issues or complaints.
- The region has held focus groups to look at needs assessment.
- Besides the newspaper and the *Link*, every week, the RHA works with the local radio station to feature various topics presented by different staff members.
- Community groups are invited, on an *ad hoc* basis, to attend weekly intake meetings held by Community Mental Health to participate and/or exchange information about their services and programs. Groups including the RCMP and consumer groups have attended these meetings.

Parkland Advisory Committee for Employment Support (PACES) Committee

The PACES Committee helps individuals living with a disability prepare for, obtain and keep employment in the Parkland Region. It was created in response to the limited number of programs available to individuals living with a disability who are seeking employment.

This committee is composed of several not-for profit organizations and provincial and federal government departments. The partnerships created through PACES allow for the sharing of information and resources to provide more effective and comprehensive services to promote the economic integration of individuals with disabilities.

The PACES Committee established a pilot project for mental health consumers in 2000. The primary purpose of this project was to provide pre-employment and placement services to individuals in the Parkland Region with mental health illnesses.

After the pilot project was completed, the committee determined that there was a need for an employment program that would serve all people with disabilities living in the Parkland Region. The Employment Exploration Alternative Program (EEAP) was established to address this need. The following departments refer consumers to participate in the EEAP program:

- Manitoba Family Services and Housing - Vocational Rehabilitation
- Manitoba Family Services and Housing – Income Assistance and Employment
- Society of Manitobans with Disabilities
- Manitoba Advances Education and Training
- Parkland Regional Health Authority – Community Mental Health
- Human Resources Department, Canada Opportunity Fund

The EEAP program combines a classroom component with work experience. Through interactive learning, the classroom component teaches individuals how to obtain and sustain employment. Both components provide an opportunity for participants to:

- Develop/maintain a positive attitude
- Increase social interaction
- Increase self-esteem
- Make a contribution to their community.

Ultimately, the EEAP Program assists individuals living with a disability to develop their employability skills and find employment. This 16- to 20-week program is believed to be the only one of its kind in Manitoba that works with all of these various agencies. EEAP is designed for people who have disabilities, including mental health concerns, physical disabilities and intellectual challenges. Because EEAP is a collaborative initiative that brings together various professionals to run the programs, it is able to provide a far greater range of services to more people than individual programs.

Parkland Regional Health Authority Psychogeriatric Program

The services of this psychogeriatric program include the provision of mental health specialists within the community, the hospital and extended health care facilities for seniors. The program has mental health proctors who work with the seniors, specialists who travel out to the region, and access to physicians in other regions through telehealth and teleconferencing.

The program is involved with the provincial network for geriatrics that meets quarterly. This network has 20 to 30 disciplines represented, including support workers and mental health resource nurses in health care facilities. The support workers are hired by the RHA and work under the direction of RHA health care professionals.

Another important component of this program is the weekly intake meetings that are attended by mental health staff from the community and the inpatient unit as well as by the rural communities of Roblin and Ste. Rose (via teleconference).

Telepsychiatry in Northwestern Ontario
Lakehead Psychiatric Hospital, St. Joseph's Care Group, Thunder Bay, ON

In order to provide access for consumers requiring psychiatric care, and support and recommendations to family physicians, Community Mental Health Services (CMHS) established a collaborative care consultative service, via telepsychiatry, to four remote, underserviced communities in Northwestern Ontario.

This collaborative care model between family physicians along Lake Superior and the team at CMHS in Thunder Bay has had some important successes and faced some limitations, both systemic and clinical, that are inherent in this model.

At the time of submission, this model was in its infancy. Over time, the program's goal is to expand to include more communities within the catchment area.

Dilico Ojibway Child and Family Services
Psychiatric Consultation Services
Hospital for Sick Children Telepsychiatry Program

Dilico Ojibway Child and Family Services is an integrated agency that provides mental health, child welfare and community health services. They serve 13 First Nations within the Robinson-Superior Treaty area of Northwestern Ontario and Aboriginal peoples living in the city of Thunder Bay and in the town and settlements of the Thunder Bay District and a portion of Algoma District. All the First Nations in this area have road access within a rural and remote region.

Dilico Ojibway Child and Family Services has four district offices located in Pic Mobert, Long Lac, Nipigon and Armstrong, as well as a regional office located on the Fort William First Nation within the city of Thunder Bay.

The mental health and psychiatric issues within the First Nations population are challenging and complex. For many years, the First Nations communities had no access to psychiatric services. Since 2001, the First Nations of this area have had psychiatric consultation services through a working arrangement with Dr. Jack Haggarty, a consulting psychiatrist. The psychiatrist has visited the area communities and seen consumers, as well as used videoconferencing capabilities and consumer visits to the main office in Thunder Bay. The consulting psychiatrist has been a valuable resource to consumers living in the First Nations communities and rural towns.

Collaboration with the local physicians and the Dilico District Mental Health counsellor has improved the case management of consumers with serious mental illnesses. The consulting psychiatrist has assisted in the capacity building of the First Nations mental health counsellors, who have professional qualifications, community college diplomas or are natural helpers in their communities. This psychiatric consultation service has recently expanded to include telephone and e-mail consultation.

Dilico Ojibway Child and Family Services has a contract for telepsychiatry consultations with the Hospital for Sick Children in Toronto, Ontario. Dilico has three videoconferencing sites, and the Hospital for Sick Children has over 60 child and adolescent psychiatrists and psychologists who provide consultation and assessment of children and adolescents with emotional and behavioural problems. In the District of Thunder Bay and Northwestern Ontario, which has only one child and adolescent psychiatrist, obtaining psychiatric services for the case management of individuals with serious behavioural and emotional problems was a real concern. This service has been instrumental in assisting the children's mental health counsellors in the case management of these children. The Hospital for Sick Children, as well as specialists on fire-setting behaviours, sexual abuse, eating disorders and gender identity issues, have been helpful for children with complex mental health problems. Providing training opportunities for the case management and counselling of children with ADHD, ODD and other behaviour problems has been particularly helpful for counsellors.

This model of specialist psychiatric collaboration with a visiting adult psychiatrist and telepsychiatry with hospital-based psychiatrists in Southern Ontario has been very successful. Consumers that needed services and community mental health counsellors who needed specialist support for case management and counselling strategies and approaches now have access to these services.

Appendix C: Tools and resources

Provincial position/policy statements

British Columbia:

Mental health policy
http://www.healthservices.gov.bc.ca/bchealthcare/mentalhealth.html

Mental health and addictions best practices
http://www.healthservices.gov.bc.ca/mhd/best.html

As part of the Ministry of Health Services, Rural Health is dedicated to providing leadership and support for collaborative initiatives in rural health development (2005).
http://www.healthservices.gov.bc.ca/rural/;

Rural and Remote Health Initiative (RRHI) (2005).
http://www.healthservices.gov.bc.ca/rural/initiative.html;

Enhancing health services in remote and rural communities of British Columbia (1999).
http://www.healthservices.gov.bc.ca/cpa/publications/rap.pdf

Alberta:

Alberta's rural development strategy helps rural communities to grow (2005).
http://www.gov.ab.ca/home/index.cfm?Page=1010
http://www.rural.gov.ab.ca/research/news-feb24d.pdf

Rural development strategy backgrounder (2005).
http://www.rural.gov.ab.ca/research/news-feb24c.pdf

Umbrella Alberta Primary Health Care Project (2001)
http://www.health.gov.ab.ca/Key/phc/resource/6.Activities_Report.pdf;

Saskatchewan:

Mental health sector study (2003) exec summary
http://www.health.gov.sk.ca/ic_sk_mhlth_sec_study_es.pdf

Mental health sector study (2003) final report
http://www.sasked.gov.sk.ca/branches/programs/pdf/spp_mental_health.pdf

Guidelines for the development of a Regional Health Authority plan for Primary Health Care Services
http://www.health.gov.sk.ca/ph_phs_publications/phs_pub_guidelines_%20for_dev.pdf

Health 2005-06 Performance Plan
http://www.health.gov.sk.ca/Health%202005-06%20Performance%20Plan.pdf

The action plan for Saskatchewan health care (2003)
http://www.health.gov.sk.ca/hplan_health_care_plan.pdf

Manitoba:

Mental health and addictions info
http://www.gov.mb.ca/health/mh/

Mental health renewal
http://www.gov.mb.ca/health/mh/renewal.html

News releases on primary health care centres
http://www.gov.mb.ca/chc/press/top/2004/12/2004-12-01-03.html
http://www.gov.mb.ca/ana/newsrelease/2005-01-06.html

Manitoba Annual Report 2003/2004
http://www.gov.mb.ca/ia/annualrpt/annual_report_2004.pdf

Presentation to Commission on Future of Health Care in Canada (2002).
http://www.gov.mb.ca/health/documents/doer.pdf

News release on Telehealth Network (2002)
http://www.gov.mb.ca/chc/press/top/2002/02/2002-02-25-02.html

For a comprehensive listing of Canadian initiatives, including descriptions and contact information, please refer to *Collaborative mental health care in primary health care: a review of Canadian initiatives. Vol. II: resource guide* (Pauzé & Gagné, 2005), available at www.ccmhi.ca.

Provincial collaboratives contacts

Nfld. & Atlantic Canada	Peter Cornish, PhD Associate Professor & Director University Counselling Centre Memorial University of Newfoundland	
Quebec	Nancy Gagné, inf. bacc. Catherine Thériault-Fortier, TS Équipe de soins et services partagés en santé mentale Centre hospitalier régional du Grand-Portage	
Ontario	Jack Haggarty MD 580 N. Algoma St., Thunder Bay, ON P7B 5G4 Tel: 807-343-4394 Fax: 807-346-5200 E-mail: haggartyj@tbh.net	Pat Rockman, Ontario College of Family Physicians 'Collaborative Network'
Manitoba	Kimberley D. Ryan-Nicholls, Assist. Prof. School of Health Studies, Brandon University	
Saskatchewan	Marilee Zaharia. PhD.	
British Columbia	Dr. Rob Lehman, Roberts Creek, B.C.	Bridges Program, Sooke, BC

Appendix D: Glossary of terms and Index of acronyms

Glossary of terms

Best practices – Activities and programs that are in keeping with the best possible evidence about what works [Interchangeable with 'Better Practices', 'Positive Practices' and 'Good Practices'] (Health Canada, 1998).

Chronic disease management (CDM) - A systematic approach to improving health care for people with chronic disease that emphasizes helping individuals maintain independence and keep as healthy as possible through prevention, early detection and management of chronic conditions (British Columbia, Ministry of Health Services, 2004).

Collaborative primary health care - The delivery of services at the first point of contact with the health system by two or more different stakeholders (health professionals, consumers, families, primary health care organizations, community agencies) working together in a partnership that is characterized by:

- Common goals or purpose
- A recognition of and respect for respective strengths and differences
- Equitable and effective decision-making
- Clear and regular communication

in order to:

- Improve access to a comprehensive range of services (treatment, health promotion, disease and injury prevention and management of chronic diseases and self-help), delivered by the most appropriate provider in the most suitable location
- Deliver high-quality and effective health care
- Make the most efficient use of resources
- Improve outcomes for the consumer

Determinants of health - Factors in an individual's living and working environment that can affect their health (e.g. housing, education, income, employment, culture, physical environment, equity).

Health promotion – The process of enabling people to increase control over and to improve their health (WHO, 1986).

Interdisciplinary – A range of collaborative activities undertaken by a team of two or more individuals from varying disciplines applying the methods and approaches of their respective disciplines.

Mental health promotion - The process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health (Health Canada, 1998).

Mental health specialist **–** An individual with mental health expertise, be it related to health promotion, prevention, diagnosis, treatment or rehabilitation

Prevention – Interventions that target risk factors for specific illnesses in order to prevent the initial occurrence of a disease, arrest or retard an existing disease and its effects or reduce the occurrence of relapses.

Primary health care - An individual's first contact with the health system characterized by a spectrum of comprehensive, coordinated and continuous health care services such as health promotion, diagnosis, treatment and chronic disease management.

Primary mental health care – Mental health services provided in a primary health care setting. Settings where primary health care can be delivered include the offices of health care providers, community clinics, workplaces, schools, homes, health care institutions, homes for the aged, nursing homes and day care centres**.** Primary mental health care may also be available by telephone, health information services and the Internet.

Recovery – A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

Index of acronyms

ADHD	Attention Deficit Hyperactivity Disorder
ASIST	Applied Suicide Intervention Skills Training
BASIS 32	Behavior and Symptom Identification Scale
BCFPI	Brief Child Family Phone Interview
CAFAS	Child and Adolescent Functional Assessment Scale
CDM	Chronic Disease Management
CCMHI	Canadian Collaborative Mental Health Initiative
CMHS	Community Mental Health Services
DATIS	Drug and Alcohol Treatment Information System
EEAP	Employment Exploration Alternative Program
InterRAI	(Resident Assessment Instrument) mental health and addiction screener
ODD	Oppositional Defiant Disorder

PACE	People Advocating for Change and Empowerment
PACES	Parkland Advisory Committee for Empowerment Support
RHA	Regional Health Authority
SASSI	Substance Abuse Subtle Screening Inventory
SHR	Saskatoon Health Region
SOCRATES	Stages of Change Readiness and Treatment Eagerness Scale
TAPPC	The Arson Prevention Program for Children
WHO	World Health Organization
WHO-DAS	World Health Organization Disability Assessment Schedule

Toolkit Series

This toolkit belongs to a series of twelve toolkits.

Implementation toolkits for providers and planners

1. Collaboration between mental health and primary care services. A planning and implementation toolkit for health care providers and planners

A series of companion documents to the CCMHI planning and implementation toolkit for health care providers and planners. Establishing collaborative initiatives between mental health and primary care services for:

2. Aboriginal peoples
3. Children and adolescents
4. Ethnocultural populations
5. Individuals with serious mental illness
6. Individuals with substance use disorders
7. Rural and isolated populations
8. Seniors
9. Urban marginalized populations

Toolkits for consumers, families and caregivers

10. Working together towards recovery: Consumers, families, caregivers, and providers
11. Pathways to healing: A mental health guide for First Nations people

A toolkit for educators

12. Strengthening collaboration through interprofessional education: A resource for collaborative mental health care educators

A series of documents examining aspects of collaborative mental health care support these toolkits:

1. Barriers and strategies
2. A framework
3. Annotated bibliography
4. Better practices
5. Canadian initiatives
6. A policy review
7. International initiatives [unpublished]
8. Health human resources
9. Mental health prevalence and utilization
10. Interprofessional education
11. Aboriginal mental health [unpublished]
12. The state of collaborative mental health care

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Bonnie Pape
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Janet Davies
Canadian Nurses Association

David Gardner
Barry Power
Canadian Pharmacists Association

Nick Kates [Chair]
Francine Knoops
Canadian Psychiatric Association

Lorraine Breault
Karen Cohen
Canadian Psychological Association

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