

Rural and Northern Community Issues in Mental Health

August 2009

Introduction

Ontario has a fragmented system of community mental health services and supports. The delivery of mental health services in rural and northern communities significantly differs from urban communities. This backgrounder identifies factors that impact the delivery of community mental health services and supports in rural and northern Ontario. Key issues that are unique to rural and northern areas are addressed, and strategies taking place in these communities to address these issues are identified.

This report is intended to inform the new provincial Mental Health and Addictions Strategy being developed to ensure equitable access to services and supports for people with mental illness and/or addictions living in rural and northern communities in Ontario. It is also intended to provide background information for other decision-makers involved in health system planning and monitoring in Ontario.

Defining northern and rural Ontario

According to the Ontario Ministry of Northern Development, Mines and Forestry (OMNDMF), Northern Ontario is comprised of 145 municipalities, 106 First Nations, over 150 unincorporated communities, and 10 territorial districts, including Kenora, Rainy River, Thunder Bay, Cochrane, Algoma, Sudbury, Timiskaming, Nipissing, Manitoulin, and Parry Sound. Northern Ontario expands over 800,000 square kilometres, covering 90 percent of Ontario's land area, and has a population density of one person per square kilometre. The 2006 Census indicates that 6 percent of the province's population lives in Northern Ontario.

Identifying Ontario's rural population is a more difficult task because there are different methods for defining "rural" areas. The concept of rurality is constantly being debated, reviewed, adjusted and altered. Due to competing definitions of rural Ontario, no standardized definition exists to help guide policy and research initiatives. Thus, the population and the boundaries of what constitutes rural Ontario vary according to the definition being used.

Statistics Canada defines rural areas as having a population of less than 1,000 and a population density of less than 400 per square kilometre.² Statistics Canada's *Rural and Small Town Canada Analysis Bulletin* recommends that a starting point for understanding Canada's rural population is to utilize the "rural and small town" definition, which is the population living in towns and municipalities outside the commuting zone of larger urban centres (i.e. outside the commuting zone of centres with population of 10,000 or more).³

The Ontario Ministry of Agriculture, Food and Rural Affairs' (OMAFRA) working definition considers rural Ontario to be all areas excluding the cities of Greater Sudbury, Hamilton, London, Ottawa, Thunder Bay, Windsor, the regions of Niagara and Waterloo, and the Greater Toronto Area. Within these nine urban areas, municipalities with a population of less than 100,000 are also considered rural.⁴

The Ontario Ministry of Health and Long-Term Care (MOHLTC) and the Ontario Medical Association (OMA) have developed a measurement of rurality for the purposes of financial incentive programs for physician recruitment and retention in underserviced northern and rural communities.⁵ The Rurality Index of Ontario (RIO) determines a community's degree of rurality based on size of population and population density, and travel times to the nearest general and advanced health care referral centres.

General referral centres are defined as settings with a population greater than 10,000 and that offer family physician, psychiatry and other speciality services. Travel time takes into consideration both the travel distance and the type of roads available.

The Canadian Collaborative Mental Health Initiative (CCMHI) uses the definition of "rural and small town" communities as having 10,000 or fewer residents that are situated outside of commuting zones of large metropolitan areas and cities. An "isolated" community implies having limited or no road access, nor ready access to specialized services.⁶

Population characteristics in rural and northern Ontario

Every definition of "rural area" will generate a different population of rural residents. Due to the sparse population in many rural communities, there is an undersampling of rural areas. At best, there are only estimates of community health status at a regional level. There is also the issue of data suppression in rural area research. Smaller units of measurement may not contain adequate population levels to meet reliability standards, and privacy and confidentiality requirements under legislation. Currently, the publicly available demographic data for Ontario tends to be divided by Local Health Integration Network (LHIN) or Health Unit, both of which have geographic areas that contain both urban and rural populations. By comparison, demographics on Northern Ontario are clearer, since the north is defined by geographic boundaries. However, the north is not uniformly rural; while mainly sparsely populated, there are some larger urban centres in the north.

What is apparent from the available data is that rural communities across Ontario are not homogenous. Community profiles paint a clear picture of a diverse population. Northern Ontario is home to 26 percent of the provincial Francophone population, 40 percent of the provincial Aboriginal population, and includes 106 of the 134 First Nations communities in Ontario. However, these populations are changing at different rates. In the Algoma/Cochrane/Manitoulin/Sudbury community, the overall population and Francophone population is declining. However, between 2001-2005, the Aboriginal population in this region increased by 20 percent. The Francophone population in the Muskoka/Nipissing/Parry Sound/Timiskaming community is 15 percent, and the Aboriginal population is 6 percent, which are much higher percentages than the Ontario average. At 17.6 percent, this region has the highest percentage of seniors age 65 and over.

Health Status

The Canadian Community Health Survey (CCHS) [2002] indicates that across Canada, the self-rated health of Canadians declines from the most urban regions of the nation to the most rural and remote areas. ^{11,12} Geographic location is thus a determinant of health. The CCHS reveals that men and women living in rural and small towns have a lower life expectancy than the average Canadian. These residents also have elevated rates of being overweight, smoking, arthritis/rheumatism and high blood pressure. Furthermore, individuals living in rural and northern areas have higher than average rates of major depressive disorder.

Compared to the provincial average, residents of Northern Ontario also have higher self-reported rates of "fair or poor" mental health. Northern Ontarians also self-report higher rates of depression. Medication use is elevated in northern communities, and the hospitalization rate for Northern Ontario is twice that of the provincial rate. A recent analysis of the need for services and supports in rural and northern Ontario revealed that compared to urban areas, individuals living in northern and rural areas are in greater need of psychotherapy or counselling. In the compared to urban areas, individuals living in northern and rural areas are in greater need of psychotherapy or counselling.

Approximately 18,000 migrant agricultural workers from Mexico and Caribbean work in 1,300 farms across rural Ontario. ¹⁵ Temporary migrant farm workers identify depression and barriers to accessing health services as two of their top health concerns. ¹⁶ Barriers to accessing services include lack of

transportation and isolation of farms, language and cultural barriers, fear of reprimand, lack of information, employer consent, no health card (for some), and fear of loss of pay or employment.

Key issues for rural and northern communities

The health status of a population is inversely related to the remoteness of its location. ¹⁷ Individuals living in rural and northern communities face multiple mental health disparities, which are differences in mental health status that are avoidable, unjust and systemically related to social inequality. Residents of rural and northern communities also face geographic disparities in access to mental health services due to multiple barriers created by their geographic location of residence. Outlined below are key issues that are unique to rural and northern areas that influence the delivery of mental health services and supports in these communities.

In Ontario, the basket of services in rural and northern communities is less comprehensive, available and accessible.

The basket of services in rural and northern Ontario is not comprehensive. Residents of these regions have limited availability and access to primary health care, specialists, hospitals and community services and supports. In Ontario, the MOHLTC designates communities as "underserviced" by physicians based on a series of factors including long-standing challenges in recruiting and retaining physicians, low health care provider-to-population ratios, travel time to reach service providers, and local demand for services. ¹⁸ Communities must apply for the designation. In terms of general and family physicians, currently there are 34 underserviced communities in Northern Ontario and 100 underserviced communities in Southern Ontario. ¹⁹ The northern LHINs as well as the LHINs with large rural populations report lower rates of family physicians practicing per 100,000 population, compared to the Ontario average. ²⁰

Only communities in northern Ontario qualify to seek designation from the MOHLTC as underserviced for physician specialists. ²¹ Seven communities in northern Ontario are designated as underserviced by psychiatrists. In 2004, the average number of psychiatrists practicing per 100,000 people in Ontario was 13.1; however, in north west Ontario, the rate was only 3.3 psychiatrists per 100,000 population. ²² Significantly lower than average psychiatrist rates also exist in several other LHINs across Ontario, characterized by large rural or northern populations. Family physicians, psychiatrists and other specialists may still be available to these communities; however, they are often only accessible for a limited time, through temporary assignments, rotation programs, telemedicine initiatives or locums. ²³

For individuals living with mental illness, there are additional barriers to accessing primary health care and psychiatrists beyond the limitations of being in an underserviced area. Information from the field indicates that family physicians are increasingly screening out individuals living with mental illness and/or addictions who have complex health needs. Even for those individuals who have regular access to a primary health care provider, there is limited access to psychiatric assessments. Often, residents of northern and rural areas are required to travel to urban centres to gain access to mental health assessments and psychiatric services.²⁴

When compared to urban areas, hospitals are fewer and farther apart in rural and northern communities. ²⁵ Furthermore, many of the hospitals that provide psychiatric services designated under the *Mental Health Act* tend to be situated in larger urban communities. ²⁶

A scan of the geographic distribution of more than 300 agencies providing community mental health services listed in the Mental Health Service Information Ontario (MHSIO) database supports information from the field, that the basket of available mental health services and supports is often less comprehensive in rural settings.²⁷ There is no consistent method to identify capacity or map

trends and gaps in services in rural communities due to the absence of a standardized definition of what constitutes a rural community in Ontario.

Transportation is a significant barrier to accessing community mental health services for rural and northern Ontarians.

Due to the diminished basket of services, individuals living in rural and northern communities must often travel to urban areas to access the health services they need. At times, residents must leave their families and support networks, and absorb high travel costs in order to gain access to the mental health services that are unavailable in their rural and northern communities. The lack of access to transportation creates potentially unsafe situations for people using mental health services, such as when individuals are discharged from services in other communities with no method of returning home. ²⁹

Outside of the larger urban centres, many rural and northern communities in Ontario do not have public transit systems. Without public transit, residents in these communities also experience the extra burden associated with the high costs of arranging private transportation or taxicabs. 30 Information from the field reveals that in some communities, volunteer drivers, arranged through community mental health agencies, help to transport residents to their medical appointments.

Accordingly, community mental health service providers often spend significant time travelling and navigating the large geography of rural and northern areas in order to provide outreach services to their clients. ³¹ Information from the field indicates that many community mental health agencies have to absorb all costs for transportation because travel costs are not considered in funding formulas or caseload benchmarks. Agencies must allocate a significant part of their resources (money and staff time) to transporting clients and providing outreach services. The result is less capacity for providing community mental health services in rural and northern communities.

The continuity of care is fragmented in rural and northern Ontario.

The availability and accessibility of a comprehensive basket of services supports continuity of care and the ability to provide a seamless system of services and supports. However, in rural and northern Ontario, there are gaps in service and coordination of hospital admission, discharge planning and follow-up care. Continuity of care in rural and northern areas is fragmented due to the lack of a comprehensive basket of services. The MOHLTC's Health Care Connect program has been effective in helping some individuals find a primary health care provider. However, even after Health Care Connect has linked an individual with a family physician, many individuals may not be accepted into a practice if they have complex health care needs due to mental illness and/or addictions.

Many individuals routinely travel to urban areas to gain access to the mental health and addictions services that are unavailable in their local community. Information from the field reveals that these individuals are often discharged from urban area hospitals without an adequate discharge plan, impeding referrals to appropriate community mental health programs in their home community. Thus, many of these individuals do not receive the follow-up care they need.

In 2004/2005, use of emergency rooms for psychiatric reasons in northern Ontario was more than double the Ontario average. Such usage is likely reflective of the fact that emergency rooms are a chief point of access into the mental health system. Residents in rural and northern communities who do not have regular access to a primary health care provider may also rely on emergency rooms for their ongoing health care needs. In particular, some individuals use emergency rooms for routine medication renewal. Thus, the lack of a comprehensive basket of services in rural and northern areas, in addition to the growing unattached patient population, places heavy burdens on the local emergency rooms.

Workforce recruitment and retention is one of the greatest challenges facing rural and northern Ontario.

Unemployment and low income rates are high in rural and northern communities.³⁴ These communities also report higher proportions of individuals who have less than a secondary school level education. The lack of employment and education opportunities drives the migration of the local labour force to urban areas.³⁵ As a result, there is a growing concern in the mental health sector regarding a future shortage of health human resources in rural and northern Ontario.

The community mental health sector as a whole, faces challenges in recruiting and retaining qualified staff. Significant wage disparities exist between the community and institutional sectors; employees of community mental health agencies are lower paid than their hospital-based counterparts working in the same communities, performing similar roles. To Some agencies across the province report having to freeze wages along with reducing service volumes and staffing levels to balance their operating budgets, when annual budget increases did not meet the cost of inflation. Staff turnover can be as high as 40 percent per year in some regions, raising the concern of the Auditor General of Ontario that uncompetitive wages are "making recruitment and retention of qualified staff difficult and eroding the capacity of the community mental health system."

These challenges in recruiting and retaining mental health workers are exacerbated by the challenges faced in recruiting a health care workforce in rural and northern regions. Health care providers are disproportionately distributed across Ontario. In 2005, the MOHLTC noted that only 5 percent of physicians practice in rural areas in Ontario, which is largely disproportionate to the population in these communities. Community-based health services face similar staff shortages. In 2002 in one northern district, over two-thirds of all health care organizations reported difficulty recruiting and retaining staff. Although salary may be one factor challenging organizations in recruiting staff, several work and lifestyle issues may also have a strong impact. Issues of professional isolation, inclement weather, transportation challenges, distance from academic or teaching hospitals, and lack of spousal employment opportunities or family resources are all likely contributors.

Lack of access to affordable housing is a key determinant of health for rural and northern Ontarians.

According the 2001 Census, 28.8 percent of all households in Ontario are renters (1,312,295 tenant households out of 4,550,030 total households). ⁴³ Thirty-six percent of Ontario's tenant households are living at or below the "poverty line." Ninety-six percent of Ontario Works' beneficiaries are tenants, and 17 percent of these beneficiaries who rent live in subsidized housing. Seventy-six percent of Ontario Disability Support Program (ODSP) beneficiaries are tenants, and 22 percent of these ODSP beneficiaries who rent live in subsidized housing. At the beginning of 2006, there were 123,182 low-income households across Ontario on the active waiting lists for social housing. ⁴⁴

For individuals living in rural and northern communities in Ontario, there is limited access and availability of social services and supports, and access to affordable housing. Information from the field indicates that the waiting lists for supportive housing can be up to 5 years. As an alternative, people are living in substandard housing, "couch surfing," or living with family or friends.

Many people living with mental health issues are homeless or under-housed. The lack of alternative housing, such as shelters and group homes, in rural and northern communities influences these individuals to migrate to urban areas in search of adequate, supportive and supported housing and away from their established social networks.

Population-based funding methodologies pose challenges for rural and northern communities in Ontario.

Comparing unadjusted per capita funding will not take into account the higher cost of providing services to areas with dispersed populations across a large geographic area. Population-based funding typically does not correct for health disparities or for inequitable access to services and supports. On average, northern area LHINs receive more per capita funding for community mental health than the other LHINs; however, there is still a lack of capacity to adequately meet the population's needs for services.

In the new regionalized LHINs, there are concerns that future funding may be consolidated and redirected to larger urban centres, requiring people in smaller communities to leave their communities, families and support networks to access more specialized care. Some areas of the province indicate pressure from LHINs on community-based organizations to integrate in rural areas. It is unclear what this integration may mean for the continued provision of services "close to home" in these communities.

Utilization-based funding formulas, such as the proposed Health Based Allocation Model (HBAM) can maintain the status quo. Basing funding on existing utilization data from the acute care system and Ontario Health Insurance Plan (OHIP) under-estimates the true need for mental health services, due to factors such as stigma keeping people from self-identifying, lack of capacity within existing settings to diagnose and report case findings, and challenges in accessing treatment with family physicians and specialists. 46

Existing strategies in rural and northern Ontario

Role of collaborative care

Multidisciplinary primary health care teams are being used in northern and rural areas to provide services for people with mental health needs due to a lack of psychiatric care. ⁴⁷ Community based mental health agencies have developed collaborative care networks, often involving agencies from other sectors, as a means of building capacity and providing support for individuals with serious mental illnesses who have complex health needs. ⁴⁸ In many rural communities, innovative collaborations have emerged in the face of limited health human resources to draw on a broader range of knowledge and skills, which include social service agencies, law enforcement, religious groups and the educational system. ⁴⁹ However, the lack of health human resources also serves as a barrier to effective collaboration. ⁵⁰

Role of telemedicine

Telemedicine initiatives are expanding to bring a range of mental health support to rural and remote communities. According to the Ontario Telemedicine Network (OTN), over 32,000 clinical telemedicine consultations were provided over the network in 2007. It has been suggested that access to telemedicine may improve recruitment and retention by connecting otherwise isolated professionals to their peers. However, expansion of telemedicine requires infrastructural investments and increased bandwidth in many rural and remote communities. Information from the field raises concerns that telemedicine is more useful for follow-up care than initial mental health consultations.

Role of consumer/survivor initiatives (CSIs)

In many rural and northern communities, CSIs have been successful in providing peer support and enhancing life skills for individuals with mental illness and/or addictions. Many CSIs participate on LHIN advisory committees and hospital advisory committees to inform the planning and delivery of services. Currently, there are 77 peer/self-help initiatives listed in the Connex*Ontario* database across Ontario, many of which are situated in rural and northern communities.⁵³

Role of the informal/voluntary sector

Informal caregivers, including family members and volunteers, are frequently involved where a formal workforce is lacking. ⁵⁴ However, informal caregivers cannot be a substitute for having access to a professional mental health workforce, and strategies need to be considered to increase the recruitment and retention of mental health workers in rural and northern communities.

Current government strategies to address the rural health workforce shortage

The government of Ontario has implemented several strategies to support the recruitment and retention of rural health workforces including financial incentives, professional development opportunities to reduce professional isolation and the development of the Northern Ontario School of Medicine. ⁵⁵ However, financial incentives may not be sufficient to address the lifestyle issues that may preclude health professionals from settling in rural and northern regions. Further, the financial incentives are directed towards physicians and psychiatrists and not towards other non-medical health providers.

The Psychiatry Outreach Program, a joint collaboration between the University of Toronto and the Centre for Addiction and Mental Health (CAMH) in Toronto, provides clinical services and supports to northern and rural communities underserviced by mental health specialists. ⁵⁶ This innovative program builds capacity in rural and northern communities through education and health promotion. The program uses strengths-based approaches to assist individuals living with mental illness and addictions.

Conclusion

Geography is a key determinant of health. Rural and northern communities face unique challenges, and these communities require customized solutions and a different approach than their urban neighbours.

The following key messages must be addressed to ensure that all Ontarians living in rural and northern communities have equitable access to community mental health and addictions services and supports:

- A standard definition of rural Ontario does not currently exist. Accordingly, there is a lack of available information on the distribution of mental health services in rural regions across Ontario. A consistent definition of rural Ontario is needed in order to measure the population health of rural residents, and to identify needs, gaps, as well as plan and monitor health services.
- 2. The basket of services in rural and northern Ontario communities is less comprehensive, available and accessible than in urban areas. A comprehensive basket of services is needed to support rural and northern residents living with mental illness and/or addictions.
- 3. Transportation is a significant barrier to accessing community mental health services for rural and northern Ontarians.
- 4. Continuity of care is fragmented in rural and northern Ontario. A comprehensive basket of services is necessary to provide continuity of care and seamless service for rural and northern residents.
- 5. Workforce recruitment and retention is one of the greatest challenges facing rural and northern Ontario.
- 6. Lack of access to affordable housing is a key determinant of health for rural and northern Ontarians.
- 7. Population-based funding methodologies without adjustments for geographic disparities pose challenges for rural and northern communities in Ontario.

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