**Chapter x.x.x**

# TEACHING MENTAL HEALTH CARE IN RURAL COMMUNITIES IN CANADA

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## Introduction

Mental illness affects many people worldwide, contributing to a burden of suffering and disability that in 2011 accounted for 25.3% and 33.5% of all years lived with a disability in low- and middle-income countries, respectively.[1] Globally, mental health services are not meeting the needs of those who require them. The 66th World Health Assembly held in 2013 declared that there is 'no health without mental health' and stated that health systems have not responded adequately to the burden of mental illness.[2]

Although the prevalence of mental disorders appears to be the same in both rural and urban areas in North America,[3-5] rural populations have poorer health outcomes.[4] These are accentuated in rural Indigenous communities with higher suicide rates, particularly in adult males and children.[5-7]

One of the solutions is to include appropriate mental health education in the training of rural health care providers, including family physicians and general practitioners (GPs). This would enable them to integrate mental health care into comprehensive primary health care, which is both more effective for the population and less costly than secondary and tertiary care.

## Resourcing mental health services

The global scarcity of mental health resources,[8] associated with increasing needs, is exacerbated by the inequity between rural and urban areas.[9] Not only are there geographical and cultural challenges to service delivery in rural regions, but urban policy and decision makers tend to apply a single solution to all rural regions without recognising local challenges and realities.[9] Service providers trained in urban models struggle to provide care, without appreciating rural cultures and circumstances.[9]

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In rural communities, the most effective way of providing mental health care is to integrate holistic mental health services within the primary health care team. This allows mental disorders to be detected and treated early, reducing the harm and burden of late treatment. Providing mental health care at the primary care level also offers more opportunities for prevention and health promotion in the community.[10]

The WHO and the Pan American Health Organization identified training of primary care staff in mental health as crucial to addressing the current limited capacity to provide treatment and care.[11] There are reports from many countries, especially those that are less developed, of insufficient training in mental health during undergraduate medical school and postgraduate Family Medicine/GP training.[11-13] The 2013 World Health Assembly called for the introduction of mental health training at both undergraduate and postgraduate levels, and for the training to be done in the field in non-specialised settings.[2]

Telehealth is available in most rural communities in developed countries and could be used to address the core problems rural populations face in accessing mental health services.[19] It is not widely used by practitioners, however, given their resistance to changes in the traditional modes of practice. This resistance can be resolved through incorporating telehealth training at both the undergraduate and postgraduate levels.[20]

## Training in and with communities

As training the medical workforce is best done in the setting that most closely approximates their future practice,[14] teaching future rural doctors about mental health is best done in rural communities.[15] Here they can learn how to work with interdisciplinary health teams and community agencies to address issues for individual patients (such as housing and support) while collaboratively developing mental wellness programmes. In this way, they can learn to deliver care in real life rural environments and cultural contexts.

As noted, high levels of mental health problems in many rural Indigenous communities in Canada have led to disproportionately higher rates of suicide than the rest of the nation.[16] This has been attributed to relocation, colonisation and residential schooling which have led to the loss of language, culture and self-identity, to abuse of alcohol and drugs, and to inter-generational trauma.[17] Despite these challenges, some Indigenous peoples have remained resilient - this is more likely to be in settings where adults and elders have maintained their traditional knowledge, values and culture and have been able to nurture younger generations.

As the land is sacred for most Indigenous cultures, being on the land provides the Inuit with a safe space, familiarity and empowerment that allows people to be connected and healthy. An NGO Movember-funded community-led land-based programme for the Inuit demonstrated that such activities promoted mental health for men, boys, families, and communities.[18]

Immersing health care trainees in providing care in Indigenous communities offers a valuable learning experience in providing holistic and 'culturally-safe' care, while engaging communities in the promotion of wellness. 'Cultural safety' is when a patient's experience of a service provider of a different culture is one in which they feel safe in terms of being respected and assisted in having their cultural location, values, and preferences taken into account.

### *Competencies*

Wonca has defined six domains of core competencies in primary mental health care[21] and the skills required for providing this care.[22] The domains are:

- values;
- communication skills;
- assessment;
- management;
- collaboration and referral; and
- reflective practice.

The recommended skills are:

- active listening and clinical interpersonal skills;
- effective assessment of psycho-social status;
- psycho-education;
- relaxation and stress management techniques;
- behavioural management;
- internet-based psychological treatments; and
- empowerment of patients to be problem solvers.

Competencies in mental health care of the Royal College of General Practitioners include organisational management and leadership, awareness of the impact of socio-cultural issues, and the ability to work and partner with public health and other external agencies in delivering mental health services.[28]

As additional competencies for providing mental health care are desirable in rural and remote communities, the curriculum of the Australian College of Rural and Remote Medicine (ACRRM) fellowship programme includes specific competency requirements for working in these settings.[23] These include:

- being able to manage mental illness in the rural and remote context without ready access to specialist, diagnostic and allied health services;
- being self-reliant and resourceful; and
- being able to use communication technology to provide medical care and to access specialised care for patients.

ACRRM also offers an additional 12 months of advanced skills training (AST) in mental health, in domains like addressing social and environmental determinants of mental health. and providing culturally safe care.[24]

'Cultural safety' is considered an important component of the College of Family Physicians of Canada (CFPC) CanMEDS-Family Medicine framework.[25] Amongst other forms of psychotherapy, CFPC certificants must learn cognitive behavioural therapy (CBT) which can be learned on-line, almost halving the face-to-face training time.[26]

Telehealth can also be used for mental health training. In addition they simultaneously promote interdisciplinary collaboration during the shared telehealth sessions in the rural setting.[27]

### Illustrative example

Northern Labrador, about the geographical size of the UK, is on the north-eastern seaboard of Canada. Over half of the population of approximately 15,000 are Indigenous – Inuit and Innu. As in most of the circumpolar world (a location within a polar region), there is a large burden of mental illness, with suicide rates more than ten times the national average.

NorFam is Memorial University's northern family medicine programme in northern Labrador, providing rural family medicine training at both undergraduate and postgraduate levels. To meet the needs of this northern rural population, NorFam enhanced the competencies required by the College of Family Physicians of Canada and the curriculum required by the main campus in the city, offering longitudinal integrated mental health (behavioral medicine) training throughout the two years of family residency training. Besides mental health workshops and reviews of videotaped interviews, trainees accessed experiential learning through the supervised provision of care via telehealth, or in person in the clinics, emergency rooms, inpatients and homes.

*Immersion*

During their family medicine training, residents (trainees) are immersed in remote Indigenous communities where they are responsible for comprehensive care under the supervision of faculty members. They learn to manage mental illness in conjunction with health promotion and illness prevention, and to address social, family and community issues in collaboration with community agencies and other health professionals. They provide shared care with the health team – which may include psychiatrists, psychologists, nurses, and Indigenous counsellors/healers and social workers – based on individual needs and with informed consent from patients.

Family medicine residents are required to show that they practice cultural safety. To assist them in doing so, they get opportunities to network with elders and elected community leaders to seek advice on community issues.

Part of the learning experience includes land-based activities. This entails trainees, along with a preceptor, living in tents with community members and learning about their cultures and traditional healing practices, while providing health services for them in the 'bush/country', instead of providing care in the hospital and clinics. Land-based activities have allowed the Indigenous peoples in northern Labrador to heal in a safe environment, reconnect with their roots and cultures, and strengthen extended family connections. Community-led land-based programmes have been adopted by Indigenous communities and have contributed to a reduction in suicides.

*Conclusion*

Training family doctors in northern Labrador has provided the region with appropriately trained family physicians who can provide holistic and comprehensive primary care, critical for addressing mental health issues in the rural and remote communities.

## Broader applicability

There is no single best model for teaching how to provide mental health care in rural communities. Each country and region can incorporate the broad principles in the development of the training model to design their own model that best meets the needs of the local population and that works within local realities of resources, geography, values and culture.

## Key issues

Patients are the greatest resource for training. If medical schools wish to be socially accountable, they should train doctors to provide services for the most vulnerable populations. This includes people living in rural and remote regions, remote Indigenous communities and refugees whose first points of entry are often in rural locations.

Rural family physicians need to be generalists with broad skills sets which include health promotion, preventive medicine, acute care, long-term care, emergency, in-patient and home care – and also expertise in mental health. This includes not only managing mental health disorders but associated co-morbid chronic diseases and addictions.[2]

Training in rural communities offers residents and medical students opportunities to learn how to address local mental health issues through research and community engagement.

## Practice pearls

- Incorporate mental health training in undergraduate medical school and postgraduate training for primary care and family medicine.
- Integrate mental health training to create a longitudinal integrated holistic training experience.
- Incorporate telehealth, research and community engagement in the curriculum.
- For Indigenous communities and those with refugee populations, embed training in the communities and ensure the practice of cultural safety.
- Incorporate training on how to engage families, other social-health disciplines and community agencies in holistic care for the patient.

## What to do

- Train in rural sites - including, where possible, immersion in Indigenous communities and refugee camps.
- Adopt a curriculum that addresses the needs of the local rural communities and a programme that fits with the local culture, value system and realities.
- Provide longitudinal integrated training at both undergraduate and postgraduate levels that includes ambulatory, emergency, in-patient and community services. As mental and physical health are intertwined, they are best addressed simultaneously.

- Teach community engagement and collaboration to address underlying issues that impact mental health.
- Include research, health promotion and illness prevention in the training.
- Teach how to use communication technology (telehealth) effectively to provide care closer to patients' homes.

## What not to do

- Do not adopt a training programme in mental health without taking into account rural realities and the culture of rural/Indigenous communities.

## Conclusion

Mental health is a crucial component of wellbeing. The burden of suffering and mortality from mental illnesses remain disproportionately higher in rural communities than urban centres.

The integration of mental health services into comprehensive primary care is the best way to improve access to mental health services. While the WHO has identified training in mental health as a critical path to addressing this issue in rural communities, there is a need to improve training in mental health care in medical schools globally. Patients in rural communities are a valuable resource for training programmes and learning how to provide mental health care for rural and remote communities is best acquired in settings that most approximates future practice.

## References

1. WHO. Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level. Report by the Secretariat; 1 December 2011. http://apps.who.int/gb/ebwha/pdf_files/eb130/b130_9-en.pdf
2. WHO. Comprehensive mental health action plan 2013-2020. Sixty-sixth World Health Assembly; 27 May 2013. http://apps.who.int/gb/ebwha/pdf_files/wha66/a66_r8-en.pdf
3. Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, Eshleman S, et al. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the national comorbidity survey. *Archives of General Psychiatry*. 1994; 51(1):8-19.
4. Mohatt DF, Bradley MM, Adams SJ, Morris CD. *Mental health and rural America: 1994-2005. An overview and annotated bibliography.* Washington, DC: U.S. Department of Health and Human Services Health Resources and Services Administration, Office of Rural Health Policy, 1994, 1-130.
5. Hartley D, Bird D, Dempsey P. Rural mental health and substance abuse. In Ricketts TC (ed) *Rural Health in the United States.* New York: Oxford University Press, 1999, 159-178.

6. Eberhardt M, Ingram D, Makuc DM,Pamuk ER, FreidVM, Harper SB, et al. Urban and Rural Health Chartbook. *Health, United States, 2001*. Hyattsville, MD: National Center for Health Statistics, 2001, 58-59.
7. Rost K, Zhang M, Fortney J, Smith J, Smith GR Jr. Rural-urban differences in depression treatment and suicidality. *Medical Care,* 1998;36(7):1098-1107.
8. Saxena S, Thornicroft G, Knapp M, et al. Resources for mental health: scarcity, inequity, and inefficiency. *Lancet*, 2007;370(9590):878–889.
9. Brant Smalley K, Warren JC & Rainer JC. *Rural Mental Health: Issues, Policies and Best Practices*. 2012 Springer Publishing Company, LLC. ISBN 978-0-8261-0799-2
10. WHO & Wonca. *Integrating mental health into primary care a global perspective.* Geneva, 2008.
11. *Regional Mental Health Atlas*. Pan American Health Organization. December 2015.http://iris.paho.org/xmlui/handle/123456789/28451 ISBN 978-92-75-11900-6
12. Rissman Y Z, Khan CT, Isaac SK, Paiz JA, DeGolia SG. Developing a mental health curriculum to build capacity and improve access to mental health care in rural Guatemala. *Academic Psychiatry,* 2016; 40:692–694. http://doi: 10.1007/s40596-016-0500-8
13. Acharya B, Hirachan S, Mandel JS, van Dyke C. The mental health educational among primary care providers in rural Nepal. *Academic Psychiatry*, 2016; 40(4): 667-671.
14. Jong M, Beach DA. NorFaM - Arural/northern family medicine program that trains family medicine residents for rural/northern practice in Canada. *Canadian Journal of Rural Medicine*, 1997; 2(3): 120-124.
15. Jong M. Health systems and funding of rural-based medical education. In: AB Chater, J Rourke, R Strasser, S Reid (Eds); *Wonca Rural Medical Education Guidebook.* Gramado, Brazil: Wonca, 2014.Chapter 1.2.1. www.globalfamilydoctor.com.
16. Pollock N, Mulay S, Valcour J, Jong M. Suicide rates in Aboriginal communities in Canada. *American Journal of Public Health*, 2016; 106(7): 1309-1315.
17. Kirmayer LJ, Tait CL, Simpson C. Mental health of Aboriginal Peoples in Canada: Transformations of identity and community. In KirmayerLJ &ValaskisGG (eds.) *Healing traditions: The mental health of Aboriginal Peoples in Canada*. Vancouver, BC: University of British Columbia Press; 2009:3-35.
18. Healey G, Cherba M, Tabish T. *Pathways to mental health wellness in Indigenous boys and men.* Movember Project Report. 2018 June. https://static1.squarespace.com/static/55e5acf6e4b0ce91b1988da7/t/5c00544d0ebbe849ad9d8f6c/1543525699340/Movember-FINAL-Report-2018.pdf
19. Brant Smalley K, Warren JC & Rainer JC. *Rural Mental Health: Issues, Policies and Best Practices.* Springer Publishing Company, LLC, 2012. ISBN 978-0-8261-0799-2.
20. Jong M, Mendez I, Jong R. Enhancing access to care in northern communities via telehealth. *International Journal of Circumpolar Health,* 2018 (in press).
21. Wonca. *Core competencies in primary mental health care.* Manuka, ACT, 2018. http://www.globalfamilydoctor.com/site/DefaultSite/filesystem/documents/Groups/Mental%20Health/Core%20competencies%20January%202018.pdf (Accessed 3 January 2019).
22. Wonca. *Wonca Working Party for Mental Health Guidance Paper - Family doctors' role in providing non-drug interventions (NDIs) for common mental health disorders in primary care*. Manuka, ACT, 2017. http://www.globalfamilydoctor.com/site/DefaultSite/filesystem/documents/Groups/Mental%20Health/WPMH%20role%20of%20FPs%20in%20non%20drug%20interventions.pdf (Accessed 3 January 2019).
23. Australian College of Rural and Remote Medicine. Primary Curriculum 4th Edition. 2013. http://www.acrrm.org.au/docs/default-source/documents/training-towards-fellowship/primary-curriculum-august-2016.pdf?sfvrsn=0(Accessed 31 December 2018).

24. Australian College of Rural and Remote Medicine. ACRRM Mental Health AST Curriculum Edition 2. Brisbane 2017. http://www.acrrm.org.au/docs/default-source/documents/training-towards-fellowship/curriculum-advanced-specialised-training-mental-health.pdf?sfvrsn=2(Accessed 31 December 2018).
25. College of Family Physicians of Canada. *CanMeds-Family Medicine 2017: A competency framework for family physicians across the continuum.* CanMEDS-FM 2017 Working Group. Mississauga, ON, 2017
26. Bennett-Levy J & Perry H. The promise of online cognitive behavioural therapy training for rural and remote mental health professionals. *Australasian Psychiatry,* 2009;17:sup1, S121-S124.
27. Cornish PA, Church E, Callanan T, Bethune C, Robbins C, Miller R. Rural Interdisciplinary mental health team building via satellite/ a demonstration project. *Telemedicine Journal and e-Health*, 2004; 9(1).https://doi.org/10.1089/153056203763317666
28. Royal College of General Practitioners UK. *Care of people with mental health problems. 3 10 Knowledge and skills guide.* London, 2019. https://www.rcgp.org.uk/training-exams/training/gp-curriculum-overview/online-curriculum/managing-complex-care/3-10-mental-health-problems/3-10-knowledge-and-skills.aspx (Accessed 11 January 2019).

## Resources

*Therapist Manuals.* Centre for Clinical Interventions. Government of Western Australia. https://www.cci.health.wa.gov.au/Resources/For-Clinicians/Therapist-Manuals (Accessed 29 December 2018)

World Health Organisation. *mhGAP intervention guide mental health gap action programme for mental, neurological and substance use disorders in non-specialized health settings version 2.0*. Geneva, Switzerland: World Health Organisation; 2016.

Royal College of General Practitioners. *GP Curriculum – Care of people with mental health problems*. https://www.rcgp.org.uk/training-exams/training/gp-curriculum-overview/online-curriculum/managing-complex-care/3-10-mental-health-problems.aspx (Accessed 29 December 2018).

Robohm, JS. Training to reduce behavioral health disparities: How do we optimally prepare family medicine residents for practice in rural communities? *The International Journal of Psychiatry in Medicine* 2017, 52(3): 298–312.

Wonca. *Wonca Working Party for Mental Health Guidance Paper - Family doctors' role in providing non-drug interventions (NDIs) for common mental health disorders in primary care*. Manuka, ACT, 2017. http://www.globalfamilydoctor.com/site/DefaultSite/filesystem/documents/Groups/Mental%20Health/WPMH%20role%20of%20FPs%20in%20non%20drug%20interventions.pdf (Accessed 3 January 2019).

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