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# What Works

## Reflections on Rural Mental Health Service Delivery

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I have been challenged to reflect on my front-line observations of what works and the barriers to effective provision of mental health and addictions services from my perspective currently working as a mental health counsellor in a small rural Family Health Team. I previously worked for several years for an urban non-profit adult Mental Health and Addictions agency. At that agency I worked out of the urban central office for a time doing strictly intakes and then for a time doing my own intakes and then providing counselling. From there I worked in a number of the small-town satellite offices doing counselling and my own intakes as well as developing a "drop in/same day" program and then moved on to several years as the concurrent disorders counsellor in the rural and remote catchment area of that agency, including two years working at the OPP sponsored "Situation Table" developed to address imminent risk situations and respond to emergent mental health and addictions issues. Prior to that I worked for several years delivering a mandated domestic abuse program. Before entering the social services field, I farmed for 30 years and worked in various blue-collar jobs to support my farming habit. This is the lens that informs this reflection.

Working two days a week for the family health team is easily the most effective provision of mental health services I have ever experienced. This

is a personal musing on what makes that so and what might make it even better.

One of the key ingredients is the multi-disciplinary team approach. As a social worker trained in the "structural approach", I tend to view mental health and addictions issues as coping behaviours rather than illness or genetic programming, so my approach is less about "diagnose and treat" than the approach of the medical clinicians I work with, but working with doctors and nurse practitioners and occupational therapists and dieticians and mindfulness practitioners, and caring front office and back office staff provides a wholistic and client (patient in their terms) centered approach, which allows trust building and engagement on whatever level the person is able to engage at. An additional strength of course is the fact that the staff are embedded in the community to a large degree and know the history and context for almost everyone who accesses the services, often going back generations.

This highlights another critical factor which is what could be called the "culture" of the team. Ours was largely created and maintained by the attitude of the founding Doctor who developed the team in response to what he saw as community need and effective response to those needs. He has been in this practice for over 50 years and takes great and justifiable pride in accepting as a patient anyone who lives in "his" community. This raises obvious problems with workload and capacity for all of us (and particularly for him). This is not the way things are done anymore and finding anyone to help him move into retirement is an ongoing issue.

Despite the problems this creates, it seems to me that it highlights what is the most important in terms of "What Works?", which is summed up in my mind as "Inclusion". This is evidenced in every aspect of the team culture and service delivery, from the willingness to accept new patients, to the provision of an urgent care clinic on Saturdays for the seasonal and

resident population, to the wholistic approach that includes mindfulness and nutrition and physical activation, to the physician coming and spending an hour with me talking to a suicidal client, to the front desk staff knocking on my door and asking me if I can talk to someone who is really distressed, to the Doc telling me “it’s easier to put out a campfire than a forest fire”, and “no-one gets better on their own” when I ask if it’s ok to provide counselling to a non-patient who is related to a patient.

This is in total congruence with modern neuroscience and countless studies which show the primary effect of any mental health counselling has less to do with the “franchise” modality than the actual relationship of trust/safety and non-judgmental acceptance of the whole person.

If we then look at barriers to inclusion or even name it as “exclusionary criteria” which prevents building relationships of safety/trust and development of self-awareness and effective skills for maintaining good mental (and physical) health, what do we see?

At the local level, it comes down to limited access to human resources in terms of time and scope of practice. In terms of mental health and addictions service delivery, there are services I cannot provide within my two days a week or with the training and skills I have. I cannot provide effective child mental health services, marriage and family counselling, intensive trauma or crisis work, casework services, intensive personality behaviour skills development, psychiatric diagnosis, medication assessment and review, intensive support with addictions issues and other specialized services.

In order to address these client needs, our lead physician instituted a weekly mental health rounds which includes external providers of these services. Most of these external providers come from urban based agencies, including hospital-based services. Pre-covid, the rounds were held in person and were very collaborative and collegial, working within the

inclusive culture of the FHT. Client needs would be discussed and coordinated plans formulated in a timely and responsive manner and adjusted as the need arose. It worked extremely well. There was what we think of as “warm hand offs”, where clients would be introduced to another provider by someone that they had an existing level of trust with. There was the minimal paperwork required to maintain continuity and ensure accountability.

Since covid, the rounds have changed to virtual meetings. While this has simplified the ability for different agencies to attend and reduces time lost to travel, which can be better spent seeing patients, the lack of direct face to face meetings makes it harder for participants to engage as effectively in a collaborative way. An outcome of this has been a change to more formal processes between agencies where the warm hand off from agency to agency has shifted to a more paper and non-healthcare provider process-based system that has resulted in delays for patients to receive the care that they need. Specific issues include:

- new and restrictive definition of “circle of care” which precludes use of any client identifier information for rounds discussion with some of the larger urban based agencies.
- insistence that all referrals must first go to a central wait list for intake assessment (resulting in a 4to 8-week delay before care is delivered). This system also does not allow for reference to geography or skills of a receiving healthcare provider and does not utilize the referring providers knowledge of the care needs of the patient.
- requirement that all residential treatment for addiction requires GAINs assessment. I was trained to administer the GAINs assessment and found it to be a shaming and disempowering

experience for clients that triggered lots of trauma dissociation and served no therapeutic purpose.

- paperwork requirements on top of intake requiring extensive ongoing documentation. I was told in my final days with an urban based agency that the expectation was to spend sixty percent of my time on paperwork and forty percent of my time providing services to clients. Is this good use of scarce mental health human resources in a time of high patient need levels?
- strict policies that remove patients from the care system: three missed calls and you're out. Cell service in rural areas is spotty at best and poverty prevents access to reliable communication and travel. In a typical day I will have a cancellation due to weather, illness, travel issues, phone issues, anxiety, family emergency, etc., etc. By definition, I am dealing with people whose lives are in some disarray and sometimes that means that a session with me is not their top priority. Accepting this has the positive feature of allowing me to respond quickly to requests for contact and at least check in with the person.
- limited number of sessions. It is unrealistic to think that every client's needs can be met in a limited number of sessions. With every client at the FHT, I am able to tell them that I want to be there for them when and if they need me and get out of the way when they are living their life. Mental health is not a defined treatment regimen such as antibiotics that are done in ten days. The nature of patient mental health needs requires an element of flexibility in appointments needed: some will need less - some will need more. The system has become less responsive to the needs of the patients in this aspect.

- rejection of referrals based on geographic service delivery boundaries. We are located close to the boundaries of two health "areas" (used to be called LHINs) and our people may have an address in one service "area" and actually live in the other area. They also access all types of services across these artificial boundaries. For instance, I deal with clients that receive hospital care in at least 10 different hospitals in two different health "areas". (I don't even know what to call them anymore). As Ontario Health Teams evolve in their mandate to provide more seamless care across the system, this needs to be explored and patient access to care, especially mental health care where residency can change frequently needs to be approached from an inclusive rather than exclusive viewpoint.
- varying eligibility criteria for service provision and rejection of referrals based on those criteria. For instance, one service requires three hospitalizations before service can be provided, another service requires psychiatric diagnosis, another service has decided that trauma has nothing to do with mental health or addictions issues, other services would require re-location to an urban center to access (intensive casework such as ACT). This approach is exclusionary rather than collaborative and reliant on the judgement of the primary care providers who know the patients the best.

There are also the exclusionary criteria applied for mental health services when people present to emergency wards at hospitals. It takes a lot for someone with a mental health issue to go to a public hospital. To be sent home without a plan for effective follow-up after being screened for suicidality (typically after a lengthy delay) deepens a sense of despair and

hopelessness for so many people. It reminds me of the one client who presented to six different hospitals and was refused help at all of them until she went into the parking lot at the last one and slashed her wrists. She was smart about it… transverse superficial cuts but she realized that was what it would take to get the help she needed.

It is frustrating because these exclusionary criteria make it difficult for competent and caring clinicians to do their job and provide the necessary care to patients. In some ways this can be seen as a contrast between urban and rural ways of doing things. I remember reviewing the literature on differences between urban and rural social work delivery when I was at university and the key difference was that in a rural/remote environment with limited resources, people relied on themselves and a network of other personally known and trusted providers to stretch their scope of practice to get the job done. In in urban work, patient volume tends to result in a more impersonal system of resource use and clinicians have to feed the algorithm and it spits out the result (eventually… maybe). While the goal may be efficiency it results in data heavy inefficiency, especially in the rural environment where the data on hand is often already sufficient for the purpose.

I recently participated in a research study looking at the experience of mental health counsellors working in mostly rural or otherwise marginalized populations. The common experience is definitely that most of our people are unable to get through the maze of exclusionary criteria to access any of the specialized programs and it's "just easier" and quicker in the end to deal with it ourselves. I'm hoping this is just a flaw in the system that can largely be attributed to urban (volume-based) systems not being attuned to rural culture but certainly many of my clients see it as a design feature and take it as further proof of their marginalization and invisibility.

I don't think that the FHT is the only model for effective service delivery, and indeed, without the inclusive culture of our team, it could be just as ineffective as any other part of the system.

Another effective model is the "Situation table" which I had the good fortune to work with a few years ago. This was initiated out of a realization by some local OPP officers that a huge percentage of their calls were for mental health and addictions issues and that this is outside their mandate but as one officer explained to me, "We're the only ones that can't say no". When the call comes in, they are required to attend.

This collaborative table was attended by most of the social service agencies in the county including school board reps, mental health and addictions, social services, victim services, probation, child welfare, etc. Anyone could bring a "situation" to the table and describe it using non identifying information. It was then assessed for risk and if the threshold for imminent risk was met, identifying information would be given and the agencies would check to see if they had involvement or should have involvement depending on their criteria for service delivery. Whoever felt that the situation was included in their criteria would get together, formulate, and carry out an action plan immediately. In the first year I believe that myself (as the concurrent disorder worker) and the probation officer who sat at the table responded to something like sixty percent of the situations because ours were the only criteria inclusive enough. This eventually levelled out as other agencies began to see how effective this type of response was and enabled their staff to respond. I don't recall the exact numbers but there was a remarkable drop in police calls and emerg. presentations for the folks who were provided service through this effort. The dual successes of this approach were that the patients got the right kind of support to serve their needs and the load on the judiciary system was reduced by diverting people that didn't need to enter a judicial process.

Again, the success of this endeavour came down to the cooperative culture created by the coordinator of the program and the leadership of a couple of the OPP officers. Reports back from other situation tables where this inclusive approach was not taken did not tend to have the same positive results.

These are models that I have seen work. I believe that is largely due to their inclusive, adaptive, and timely response.

In order to illustrate what all this means in a real-life situation; it has been suggested that I present a fictional situation to illustrate what works and what doesn't.

**Situation #1**

So, our receptionist knocks on my door and tells me she has a long time (2nd generation) patient on the line who is really upset and asks if I can speak to them. The lead physician in our clinic was her parent's doctor and actually delivered her and has been her doctor all her life, other than a few years when she was out west. The client I was booked to speak to has just called to say that she has a really bad headache so we have rescheduled for 3 weeks from now, with the understanding that she will call in the meantime and leave me a message for my "stand by list", if things get bad. We've discussed before that she could go to the hospital but on three previous occasions when she did this, she was sent home without any treatment after a lengthy wait in ER.

So, I am able to pick up the phone and "have a chat". Quick song and dance about limits to confidentiality and the story emerges of a woman who has worked all her life in various blue-collar jobs and been through a number of unsatisfactory relationships. She has three kids with two different fathers. Two of them live independently and one is still at home and going to high school. She has used alcohol and marijuana since she was

in her teens. A year ago, she met a man, and they developed what she describes as the healthiest relationship she has ever been in. Her kids all like him and he treats her with kindness and respect. They got married three weeks ago and went to the Dominican for their honeymoon. She had reduced her drinking and cannabis consumption to minimal levels in this new relationship but drank heavily in the resort and ended up physically assaulting her husband, who was subsequently hospitalized with non-life-threatening injuries.

They have returned to Canada, and he has moved out to live with his sister. She is terrified that she has destroyed this relationship and determined to end the control that alcohol has had on her life. Her children are furious with her, and her entire life is out of control.

She asks me for immediate referral to an addictions counsellor. I tell her I can do that and fill out the paperwork. She asks when she will hear from them, and I tell her it will be about three or four weeks. She tells me that she won't be here anymore. It's now or never. We talk some more and I tell her I will call in a personal favour and call a worker I know that can maybe get her hooked up with the AA meetings today. I call this worker and she tells me that she will call the woman today and relay the information but it's really important that her agency doesn't ever hear that she did this, or she might lose her job, because this client lives outside of her catchment area.

I call the woman back when I get a chance later in the day and my friend has called the woman and she is going to a meeting in a neighbouring town tonight.

I send in the referral and continue to check in with this client each week. She finds a sponsor in AA and reports to me that she is able to maintain sobriety and is working to rebuild her relationships.

Six weeks later she tells me that she got a call from the intake for addictions services and thought she should go through the process but became angry with the questions and told them she didn't need their help anymore.

Occasionally she calls me to discuss some of the incidents of childhood and relationship sexual assault in her life that she is beginning to recognize she was self-medicating with alcohol to cope with. I would like to refer her for intensive trauma therapy, but the publicly funded system does not provide this and she doesn't have the money for enrolment in a fee for service program.

**Situation #2**

A 32-year-old male is referred by the Nurse Practitioner for mental health counselling. His family has been rostered with the clinic for 45 years and live on a backroad about 20 minutes away. They live in this county, but their mailing address is through a post office in the neighbouring county. This man is also rostered with the clinic but has been living and working in the city for years. Recently he was in an accident which resulted in a brain injury and severe body trauma. He has recovered mobility but still suffers chronic pain which appears in different parts of his body and has proven difficult to diagnose or treat. His relationship in the city broke down and he has moved back with his family but there is constant conflict with his father. He managed to buy a lot just outside the village and a mobile home to put on the lot with his savings and the insurance money but had run out of money before he was able to do the municipally required upgrades to septic and hydro. He is eligible for some grant money and would also receive some money if he was able to do his taxes, but the brain injury keeps him from organizing his paperwork and he gets frustrated and reactive, and this alienates his family further.

We agree that it would be good to get a caseworker to help him sort through the paperwork and move towards getting into his home. I fill out a referral and fax it in. I ask the caseworker at the next mental health rounds if she has received or even seen the referral. I cannot refer to this client by name, only first name and last initial. His is a common name in the area. This caseworker (who is excellent!) is only able to attend our mental health rounds once a month and once a month her agency sends an intake worker. I ask the intake worker the next time she is there. I keep asking for 3 months, first the caseworker, then the intake worker (oh, except she doesn't show up at rounds a couple of times).

Finally, we discover that the referral was sent to the mental health services in the next county, because the postal address was in that county. When I call that agency, I am told that they will not provide casework services because the property he is trying to move into is not in their county, and in fact his residence is not in their county.

I resend the referral to the original agency explaining all the confusion. They put him on the wait list for intake. Six weeks later they attempt to call to do an intake but are unable to connect. I know that the cell service is bad at their place and his parents also make it a point to not answer any call with an unknown number and call to urge him to call them. He does that but becomes angry with the questions and hangs up on them.

I have lost touch with this client. I saw his sister at the grocery store, and she said he went back to the city, but they have lost touch with him and are afraid he's at the shelter and "probably using drugs" in her words.

These fictional scenarios are unfortunately based on real life situations. It doesn't have to be this way and some of the veteran clinicians in our team assure me that it didn't use to be this bad when we had collaborative and

timely client centered mental health rounds with external agencies. They tell me, “They took something that worked… and broke it”.