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Association des étudiant·e·s de médecine de l'Ontario

POSITION PAPER

INADEQUATE MENTAL HEALTH SUPPORTS IN RURAL AND NORTHERN ONTARIO COMMUNITIES

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INTRODUCTION

When compared to the rest of Ontario, individuals living in rural and Northern Ontario report poorer mental health than those living in urban communities in the province.[1] Northern Ontarians self-report higher rates of depression.[1] There is also higher use of prescription medications in Northern Ontario than in urban communities, particularly sleep aids, antidepressants, and anti-anxiety medications.[1,2] Furthermore, Northern Ontario has approximately twice the hospitalization rate for mental health concerns compared to the rest of Ontario, especially for suicide-related hospitalizations.[2] Compared to urban areas, residents in rural and Northern areas are also in greater need of psychotherapy and counselling.[1] The fragmented mental health system in rural and Northern communities significantly differs from the mental health services readily available in urban communities and is a contributing factor to these concerning statistics. This especially affects the Indigenous peoples who comprise approximately 2.8% of Northern Ontario's population.[3] Indigenous peoples in these communities face many challenges, including inequitable access to health care and residential school trauma that influences overall mental health and wellbeing.

In addition to the limited mental health services, there are several risk factors unique to individuals living in rural and Northern communities in Ontario that contribute to their poorer mental health. These risk factors include increased social isolation, lower socioeconomic status, reduced educational attainment, agricultural stressors, increased risk of intimate partner violence, heightened social stigma surrounding mental illness, and a higher population of older adults and Indigenous peoples living in rural communities.[4, 5]

INCREASED SOCIAL ISOLATION

Geographical location has an impact on the physical, mental and social health of those living in rural and Northern communities. These populations have unique challenges such as transportation barriers, limited community resources, and restricted access to healthcare, which can result in social isolation and worsened downstream health outcomes.[6] Increased social isolation is also a risk factor for suicide, explaining, in part, the higher rates of suicide in rural communities. A survey concluded that rural and remote communities self-report poorer mental health including higher rates of major depressive

disorder, thus contributing to the increased rates of suicide.[1] The survey also reported that not only are geographical barriers associated with high rates of depression, but these barriers also impact physicial health contributing to increased rates of comorbidities such as high blood pressure, arthritis, and obesity, leading to a lower life expectancy.[1]

LOWER SOCIOECONOMIC STATUS AND EDUCATION ATTAINMENT

The Canadian Mental Health Association (CMHA) highlights unemployment, lower socioeconomic status, and a lack of affordable housing in rural Ontario as additional factors contributing to the reduced accessibility of mental health services in rural areas.[1] These communities also report lower income rates and higher proportions of individuals who have less than a secondary school level education.[1] In 2015, communities with a population of 50,000 or less had an average income of $40,000 which is less than the Ontario average .[7] Income contributes to the overall socioeconomic status which is a well-known risk factor for poorer mental and physical wellbeing.[8] Due to poorer health status, men and women living in rural and remote communities have a lower life expectancy of 77.9 years compared to urban communities' life expectancy of 79.4 years.[9]

AGRICULTURAL AND ENVIRONMENTAL STRESSORS

Mental health concerns in the agricultural industry are becoming more prevalent.[10] Compared to the general population, individuals in this industry report higher rates of stress and mental illness, and experience higher rates of suicide.[10] A contributing factor to their poorer mental health status is the demands that come with this line of work. Moreover, farmers report that time constraints associated with their job often require them to neglect their own physical and mental health in favor of attending to their work. Another occupational stressor involves the use of pesticides and fertilizers.[11] These chemicals contaminate air and groundwater, and impact animal health.[11] Contamination of a community's water supply impacts their access to clean water and puts livestock at risk. This can greatly reduce food security in rural communities by affecting hunting and fishing and it can also impact the strong agricultural reputation amongst farmers.[11]

INCREASED RISK OF INTIMATE PARTNER VIOLENCE

In rural, remote, and Northern communities there is an increased rate of intimate partner violence.[12] Although less than 20% of the Canadian population lives in rural and remote areas in Northern Ontario, in 2019, 38% of women and young girls from these regions were victims of domestic homicides.[12] As these communities are often tight-knit, there is concern surrounding anonymity and confidentiality when reporting intimate partner violence and accessing appropriate services in their communities.[12] This lack of anonymity may lead to increased stigma faced by victims of intimate partner violence and may actually prevent them from coming forward in order to protect themselves.[12] There may also be concerns surrounding transportation, emergency housing, or even losing their children if they leave the abusive relationship.[12] Additionally, support services often available to victims of intimate partner violence are less readily available in smaller, isolated communities.[12] Due to the limited services available, victims of intimate partner violence often experience significant mental health issues such as depression, post-traumatic stress disorder, and suicidal ideation.[13] Victims of intimate partner violence also struggle with insomnia and increased anxiety.[13] This negative impact on their mental health may put them at an increased risk of misusing alcohol and illicit substances to cope with the trauma they have experienced.[13]

STIGMA SURROUNDING MENTAL ILLNESSES

While the interconnectedness of rural residents may be a protective factor for mental wellness, they also tend to experience an increased sense of stigma when accessing mental healthcare services in their community.[14,15] The stigma likely stems from the fact that most rural residents greatly value resilience, strength and self-reliance, which discourages individuals from seeking mental health support.[15]

This is most commonly seen in rural seniors, male rural residents, and certain rural professions.[16,17] In Canada, young men in rural areas have greater concerns about depression and are at the greatest risk of suicide.[16] Compared to urban areas, the increased suicide rate is due to the negative mental health outcomes that stem from limited access to mental healthcare services in rural and remote communities.[15] Interestingly, although farmers have lower rates of mental illness in these areas compared to the general population, they have high rates of suicide and are more likely to report that "life was not worth living."[15] This may imply that they are skeptical in seeking mental healthcare and this may be contributing to under-reported statistics.

AGING POPULATION

Compared to their urban counterparts, older adults in rural communities tend to have poorer physical and mental health, increased stressors, and increased prevalence of chronic illnesses such as hypertension, obesity, arthritis, and depression.[6] This susceptibility is further exacerbated by inadequate access to home care or assisted living, transportation barriers, and a lack of primary healthcare services available to them in their local community.[6] As of 2014, there are 627 long-term care facilities in Ontario, however, only 66 of those facilities are located in Northeastern and Northwestern Ontario, including its urban areas .[18]

INDIGENOUS PEOPLES

The historical trauma faced by Indigenous peoples as a result of residential schools continues to affect their physical and mental wellbeing.[19] This devastating impact has resulted in increased rates of depression, suicide, and abuse among individuals who had a family member attend a residential school.[19] These mental health concerns are associated with stressors including childhood trauma and discrimination.[19] Compared to the non-Indigenous population, Indigenous peoples report increased use of alcohol and illicit substances to cope with the intergenerational trauma they have endured.[19] The history of residential schools has also impacted the social determinants of health of this population. Poverty, low employment rates, housing and food insecurity, and discrimination are significant contributors to the mental health and social challenges Indigenous peoples' face in their daily lives.[19] Additionally, Indigenous youth are at an increased risk for suicidal ideation and suicide attempts compared to the general population.[19] However, feeling a sense of pride about culture and integrating values and beliefs into everyday life has been shown to decrease substance use. Thus, integrating culturally sensitive knowledge into their lives may be a cornerstone to achieving community mental wellness.[19]

INADEQUATE ACCESS TO MENTAL HEALTH SERVICES

One of the most significant contributing factors is the lack of equitable access to mental health services in rural and Northern communities, resulting in increased rates of suicide in these regions.[20] Inadequate resources and limited availability of healthcare professionals within the community results in barriers to accessing mental health services.[15,20] The limited access to physicians is due to the ongoing challenges with recruiting and retaining them in rural and Northern communities. Moreover, healthcare services are widely dispersed geographically or require travelling to Southern centres in order to obtain mental healthcare services. Thus, individuals often have to pay extra travel costs and leave their families and social support systems to access care, which are additional sources of stress and anxiety.[20] This puts individuals in unsafe situations as once they are discharged from the services in the urban centre, they have no transportation arranged to return to their home community.[1] This also results in a poor discharge plan as individuals are unable to receive the follow-up care they need and deserve.[1] In addition, demographically, a higher proportion of Indigenous peoples live in rural communities and face increased barriers arising out of the effects of colonization, leading to a mistrust towards the healthcare system. There are also concerns regarding inadequate access to healthcare in Indigenous communities as a consequence of physician shortages on reserves. Western perspectives are deeply embedded into the

Canadian healthcare system, which can also reduce the accessibility of mental healthcare for Indigenous people due to culturally inappropriate services.[15] Therefore, it is evident that, based on the cultural diversity within Northern Ontario and the risk factors associated with poor mental health of those living in rural and Northern communities, there is an increased need for adequate access to community-based, culturally sensitive psychiatric assessments and government-funded psychotherapy and counselling in rural and Northern areas.

IMPACT OF COVID-19

Especially during the COVID-19 pandemic, with 44% of Ontarians reporting their mental health has deteriorated since March 2019, it becomes more crucial than ever to address the mental health of rural and Northern Ontarians.[21] 1 in 10 Canadians reported their mental health has significantly worsened as a result of the COVID-19 pandemic.[22] Additionally, the Canadians who reported worsening mental health were also more likely to increase their alcohol and substance use.[22] Those with pre-existing mental illness are at an even higher risk as the fears and anxieties related to COVID-19 can have a greater impact on the mental wellbeing of this population.[22] This may be due to the pandemic restrictions, which have resulted in disruptions in mental health services provided to these individuals, and although some services are offering services virtually or by telephone, individuals living in rural and Northern communities may not have the means to participate in virtual mental healthcare.[22] To support those living in rural areas, Canadian medical students recently started the Rural and Isolated Support Endeavor which was created during the COVID-19 pandemic to provide emotional support to patients experiencing increased isolation due to the pandemic restrictions, such as quarantine and physical distancing guidelines.[23] Although these students do not provide medical advice or arrange medical appointments for these patients, they are present for social connection and mental health support.[23]

In conclusion, it is evident that prior to the COVID-19 pandemic, there were inadequate mental health supports available in rural and Northern Ontario. It is also clear that the pandemic restrictions are having an impact on individuals' mental health, which is placing additional strain on the mental health system in Northern Ontario.[22] Thus, a long-term, province-wide response that includes mental health resources, community supports, and upstream investments is needed.

PRINCIPLES

The Ontario Medical Students Association (OMSA) puts forward the following principles to guide recommendations for addressing inadequate mental health supports in rural and Northern Ontario communities:

1. Residents of rural and Northern Ontario, including marginalized populations (i.e. Indigenous peoples), deserve equitable, culturally safe and timely access to mental health services that are adapted to their unique needs and lifestyles.
2. Rural communities should be able to access support and resources in their home communities.
3. Medical education should include mental healthcare training and exposure to rural experiences in order to grow the rural workforce.

RECOMMENDATIONS

The Ontario Medical Students Association recommends the following:

A. The Government of Ontario should create a province-wide multi-modal strategy focused on improving accessibility to mental healthcare services in rural and Northern Ontario.

COMPREHENSIVE OHIP COVERAGE OF VIRTUAL MENTAL HEALTHCARE

A common barrier for accessing mental healthcare for rural residents is that they often have to travel long distances to obtain psychiatric services and healthcare at faraway institutions, resulting in significant financial burden, separation from support systems, increased anxiety, and poor discharge plans.[24] Therefore, especially during the COVID-19 pandemic, technology-based solutions like virtual care seem favourable as it can connect psychiatrists and other mental health workers to the patient. In alignment with this proposition, the Ontario Ministry of Health and Long Term Care (MOHLTC) is currently funding the Ontario Telemedicine Network (OTN), which is a not-for-profit organization and the largest telemedicine service provider in Canada.[25] In fact, 49% of OTN's total telemedicine activity takes place in Northern Ontario and has demonstrated many benefits including improved access to health services, decreased travel time and costs for clinicians and patients, and facilitation of professional development opportunities for healthcare providers.[26] To enhance virtual access to care, on November 4, 2020, the Ontario government announced a historic investment of nearly $1 billion over six years to improve and expand broadband and cellular access across the province, including in rural, remote and Northern communities.[27]

Despite expanding virtual healthcare facilities in rural and Northern Ontario, barriers still persist. In early 2020, the Ontario MOHLTC released new Ontario Health Insurance Program (OHIP) billing codes that enable physicians to provide telephonic mental health counselling to patients. However, it does not cover telehealth consultations by psychologists and other non-physician registered mental health providers.[28] Several problems exist with this physician-first model. First, making primary care physicians first-line for emergency virtual mental healthcare will put additional pressure on the already overburdened low-resourced and poorly-staffed rural healthcare system and will put extra stress on overworked rural physicians.[28] Second, the physician-first approach may result in undue pressure on physicians to provide specialized mental healthcare that they have not received training for, like psychotherapy (which can be harmful if provided in an improper manner by an untrained individual), resulting in suboptimal care that is not evidence-based.[28] Third, this approach fails to improve patient access to psychologists and other non-physician registered mental healthcare providers who may have the capacity to provide equally effective emergency care compared to pharmacotherapy and at low costs.[28] Having access to these care modalities is especially important considering the current shortage of psychiatrists and other OHIP-covered virtual mental health services.[28]

Therefore, OMSA encourages the MOHLTC to expand OHIP to cover telemedicine services, which encompass a wider range of mental healthcare providers including psychologists, nurses, therapists, social workers and other essential mental healthcare providers, so that rural patients can truly benefit from the virtual care project by the Ontario government.

RECRUITMENT AND RETENTION OF MENTAL HEALTHCARE WORKERS

Evidence shows that many rural residents may still be resistant to the concept of virtual care, and rather favor more traditional methods of obtaining care like in-person visits to mental health service providers.[15] However, many providers tend to cluster into urban centres, causing rural areas to be underserviced and worsening the already limited access to rural mental health services.[15] For example, psychiatrists in Ontario are primarily providing service in urban Local Health Integration Networks (LHINs) such as Toronto Central and Champlain, while there is a sparsity in rural LHINs such as Central East/West and North East/West.[15] Moreover, research shows that urban psychiatrists tend to be earlier in

their careers, whereas rural psychiatrists tend to be closer to retirement, which forecasts a looming crisis of available psychiatrists in rural Ontario unless rural recruitment efforts are enhanced.[29] However, there are many challenges in recruitment and retention of providers in rural areas. Besides salary, 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 commonly reported reasons for this difficulty.[1]

Therefore, OMSA recommends that the Ontario government should put greater focus on increasing recruitment and retention of diverse healthcare professionals in rural communities. This may be done through the expansion of the provincially-funded health professional loan forgiveness programs to include psychologists, social workers and other mental health professionals who agree to work in rural areas, as well as systemic efforts to better integrate rural mental healthcare providers into their new communities (i.e., housing subsidy, spousal support, etc.). To address the issue of professional isolation, OMSA also recommends accelerated promotion of programs like the Extension for Community Healthcare Outcomes (ECHO) Ontario Mental Health or Champlain Building Access to Specialists through eConsultation (BASE) within rural and Northern Ontario. ECHO Ontario Mental Health uses a "hub-and-spoke" capacity-building model that connects frontline physicians with expert interdisciplinary teams through weekly videoconferencing in order to share best practices, recommendations and provide support with mental health and addictions care provision.[30] Similarly, Champlain BASE connects rural primary care providers with urban psychiatrists in order to facilitate opportunities for bidirectional information flow and provision of efficient, integrated, and coordinated psychiatric care.[15, 31]

COMMUNITY-BASED COLLABORATIVE CARE MODELS

Different medical and community services within rural and Northern Ontario are geographically scattered from each other, necessitating increased multi-directional travel on the patient's part to access them separately. It is evident that community-based collaborative care approaches may be more effective for healthcare delivery. The Assertive Community Treatment (ACT) model, introduced in Wisconsin in the 1970s, extends 24-hour psychiatric treatment, rehabilitation and support services from an interdisciplinary team involving nurses, occupational therapists, psychiatrists, social workers and addictions specialists with a focus on patient-centered care.[15] A study on a Newfoundland and Labrador-based ACT program revealed that ACT can be profoundly effective in rural Canada with high fidelity implementation, although not originally designed for the rural context.[32] While a lack of resources and limited availability of staff to provide 24-hour care can be a challenge in rural settings, the literature demonstrates reduced emergency room visits, increased staff retention and was associated with high patient satisfaction.[24,32] In 2013, the Ontario Hospital Association (OHA) developed an alternative health service delivery model called the "Local Health Hubs for Rural and Northern Communities" with the goal to enhance access to multi-disciplinary rural healthcare services.[15] This model delivers a full span of healthcare services, including mental healthcare, at a single "hub" like a rural hospital or center to facilitate better communication between healthcare sectors, ultimately leading to increased screening, treatment and rapid referrals for mental health concerns.[15] In addition, this model allows virtual psychiatry programs based in urban centres to be delivered to rural communities through these hubs, so that the local staff can ensure these programs remain relevant to their patients' rural lifestyle context.[15] Although this model is promising to improve access to mental healthcare for patients in rural Ontario, it is still in its infancy and has only been adopted as a pilot project by eight hospitals in Ontario with the results of the pilot project pending release.[15] However, in the US, this model has been shown to improve access to quality care, decrease emergency visits and hospitalization rates, as well as increase patient and provider satisfaction.[33]

We therefore encourage the Ontario government to intensify expansion of collaborative care models, such as ACT and Local Health Hubs approaches, to all rural and Northern hospitals of Ontario as a means to improve equity and accessibility of mental health services, and healthcare as a whole, for the diverse populations living in rural and Northern Ontario.

CULTURALLY-SAFE CARE FOR INDIGENOUS POPULATIONS

Historically, Indigenous populations have been exposed to grave systemic racism and injustices in the healthcare system, from being treated unethically in nutritional experiments at residential schools to the catastrophic implementation of tuberculosis sanatoriums.[34,35] Moreover, the foundation of the Canadian mental healthcare system is currently based on settler perspectives, which may be different from the Indigenous concept of mental health and illness.[15] This has led to widespread mistrust in the healthcare system, which poses a barrier to accessing mental healthcare by many Indigenous patients. Thus, to foster better relationships with Indigenous populations and enhance access to healthcare, provision of mental health services should be culturally safe and responsive to Indigenous values, beliefs and lifestyle.[15,36] There is emerging evidence supporting improved health outcomes, patient satisfaction, and decreased litigation rates with the practice of culturally competent care and implementation of cultural competency training for healthcare workers.[37]

Alongside implementation of all of the Truth and Reconciliation Commission of Canada's Calls to Action, OMSA particularly recommends that the Ontario government incorporates cultural practices such as traditional healing practices and Elders as part of mental healthcare delivery as indicated by Call to Action #22.[38] Moreover, OMSA calls upon the government to increase recruitment and retention efforts of Indigenous mental healthcare providers, as well as to make cultural competency training mandatory for all healthcare providers as per Call to Action #23.[38] The ACT and Local Health Hubs models may be ideal for implementation of culturally safe Indigenous mental health services, as they foster the development of holistic, culturally safe and culturally appropriate services based on input from the local community.[15] For example, Local Health Hubs can also include traditional healing services for First Nations patients.[15] Incorporation of programs like ECHO Ontario Mental Health into these collaborative care frameworks can also offer culturally relevant support for rural healthcare workers in First Nations, Métis, and Inuit communities, and helps to ensure that Indigenous perspectives are heard and used to guide care.[15]

B. The Association of Faculties of Medicine of Canada (AFMC) should encourage the Faculties of Medicine across Canada to increase opportunities of exposure to rural mental health practice for medical students.

RURAL PRACTICE EXPERIENCE IN UNDERGRADUATE CURRICULUM

In the undergraduate section of AFMC's Future of Medical Education in Canada (FMEC) 2020 consultation report, *Recommendation 1: Address Individual and Community Needs* was ranked as the highest priority by the Faculties of Medicine.[39] This recommendation requires physicians and Faculties to respond to the diverse needs of individuals and communities throughout Canada and globally. Therefore, it is hopeful that medical schools across the country will be willing to address the current mental healthcare workforce deficiency. However, *Recommendation 6: Diversify Learning Contexts*, which requires Faculties of Medicine to provide learning experiences throughout undergraduate education for all students in a variety of settings, ranging from small rural communities to complex tertiary health care centres, was ranked as second last in importance.[39] Literature suggests that developing an understanding of health and illness in the rural context through hands-on experience as a medical student increases the number of students choosing rural residency programs and establishing future practice in rural communities.[40,41] Similarly, a 2018 report by the Coalition of Ontario Psychiatrists encourages

pre-clerkship exposure to psychiatry, as it has been shown to have a positive influence on recruitment to psychiatry residency programs.[15] In other words, in the context of rural mental health, *Recommendation 1* of the FMEC cannot be achieved without also prioritizing *Recommendation 6*.

OMSA therefore calls on the AFMC to encourage the Faculties of Medicine across Canada to prioritize *Recommendation 6* through the provision of rural-based training experiences for both pre-clerkship and clerkship medical students, with an emphasis on rural mental health, as delivered by committed rural physician preceptors. This will foster greater interest and future success in sustaining a rural practice.[42] For example, the Northern Ontario School of Medicine (NOSM) recently launched the Rural Generalist Pathway, which prioritizes rural learning experiences, targeted skills development, faculty mentorship and networking.[43] Replication of this rural exposure-based model at other medical schools in Ontario, as well as ensuring that the topic of rural mental health is incorporated into the curriculum, can help medical students to generate interest to work in rural areas, including mental health services, in the future. To assist in putting this recommendation into effect, OMSA can collaborate with the individual Faculties of Medicines within Ontario to create guidelines for incorporating rural-based mental health learning objectives into pre-existing medical courses.

ESTABLISHING RURAL MEDICINE INTEREST GROUPS IN ALL MEDICAL SCHOOLS

Many Canadian medical schools have rural medicine student groups, which are intended to nurture students with an interest in rural medicine. For example, the NOSM Rural Medicine Interest Group (RMIG) aims to share the beauty and challenges of rural medicine through collaboration with physicians working in Northern Ontario as well as discusses the incentives available to those who practice rurally after graduation. A study confirmed that exposure to rural medicine through participation in a RMIGs significantly contributed to McMaster medical students' interest to work in rural communities.[15] However, at the time of writing this paper, in some other medical schools like Queen's University and University of Ottawa, the portfolio of rural medicine is under the jurisdiction of the Family Medicine Interest Group (FMIG). This model can restrict adequate exposure of students to rural medicine, as the broad scope of Family Medicine limits the number of rural-themed events within the year and also gives the false impression to students that only family physicians can work rurally. In fact, rural medicine can include rural psychiatry, surgery, anesthesia, emergency, obstetrics, internal medicine and other specialties.

Therefore, OMSA recommends all Faculties of Medicine to encourage the establishment of separate RMIGs at each medical school. We recommend that the OMSA Northern Ontario and Rural Medicine (NORM) committee promote this movement at the medical student level. Once all six Ontario medical schools have established RMIGs, we recommend that the NORM committee host networking opportunities for the different RMIG's within Ontario, principally in the form of a half-day virtual annual general meeting. These meetings will include presentations by the different RMIGs about their ongoing projects and initiatives, presentations by the NORM committee about current and upcoming projects, keynote speaker sessions about rural medicine and other relevant educational and fun activities. Each school will have a minimum of two representatives and an unlimited number of delegates. We hope that this networking event will help to unite the different RMIGs, generate discussion about common issues and solutions, as well as build a strong medical student community within Ontario who are passionate about rural medicine.

C. The Government of Ontario should organize peer-support initiatives that promote skills development as a means to help reduce stigma around mental health and empower rural communities to help themselves.

Although mental health services are limited in rural areas due to a shortage of mental healthcare providers, stigma may actually prevent individuals from seeking available mental health treatment in rural and Northern communities. One of the primary concerns that individuals in these communities raise is lack of anonymity, as discussed in the *Stigma Surrounding Mental Illness*.[14] Thus, motivating individuals to seek mental healthcare cannot be achieved unless social tolerance is developed in rural communities.

Research shows that interventions that focus on imparting information are often less successful than skills development-based interventions to address the stigma surrounding mental health.[24] Mass media awareness-raising campaigns are examples of information-imparting interventions that are often conducted to improve social tolerance by creating discussions about mental health with the intention to make this topic less taboo.[44] However, studies have reported mixed, limited or no impact of awareness campaigns on stigma reduction, and in fact, sometimes may make it worse.[44] A notable case was the *Open Minds* anti-stigma campaign that was established by the Mental Health Commission of Canada in 2009 that used various sources of mass media to transmit messages emphasizing mental illness treatment and recovery.[44] First-person accounts of people who had experienced a mental illness were also shared.[44] However, post-campaign surveys showed little to no change in people's opinions, causing the program to change to a more intensive and targeted approach to stigma reduction instead of media messaging.[44] Therefore, anti-stigma information-imparting campaigns may not be the most effective approach to developing social tolerance in rural communities.

Instead, due to the self-reliance and social connectedness of rural populations, programs that empower rural residents to develop skills to better support the mental health needs of one another may effectively complement healthcare restructurings.[45] Skills development initiatives like public mental health literacy programs, Mental Health First Aid training and Consumer/Survivor Initiatives (CSI) have shown great effectiveness.

A recent example of a promising public mental health literacy initiative in the rural context is the newly launched *In the Know* mental health training program by the Canadian Mental Health Association (CMHA).[46] This program is specifically designed for farmers in rural and agricultural communities across Ontario and provides participants the opportunity to discuss mental health openly and safely using farming-specific scenarios.[46] An evaluated pilot project showed that the training effectively increased participants' mental health knowledge, ability to recognize and discuss mental health struggles, as well as confidence in helping others who are having a mental health crisis.[47]

Another successful peer-support approach is Mental Health First Aid training. This was initially developed in Australia intending to utilize the significant role that the public can play in supporting an individual with a mental illness.[48] It was also found to be helpful in the rural context where support from community members is more readily accessible than medical care.[48] The training equips individuals with the skills to assess the risk of suicide or self-harm, listen non-judgmentally, give reassurance and information, encourage seeking professional help and share self-help strategies.[44] Numerous studies of this method in the rural context have found that trainees are better able and more likely to help others regarding mental health issues, which leads to positive effects on confidence to respond, increased empathy, stigma reduction and better handling of crises.[44, 48]

In addition, CSI is a peer-support and life skills teaching program run for and by people with mental health problems and/or those who have received mental health services.[49] Studies imply that CSI support can improve recovery, reduce hospitalization, as well as decrease the use of crisis and other expensive services.[49] Lists of CSI peer/self-help initiatives can be found on the ConnexOntario database, many of which are available in rural and northern communities.[1]

In culmination, we recommend the Ontario government to continue the establishment of CSIs in rural and Northern Ontario in order to promote peer-support interventions and to reduce stigma. We also recommend the Ontario government to collaborate with CMHA to develop a rural-specific mental health literacy program using a similar model as *In the Know*. This mental health literacy program as well as Mental Health First Aid training opportunities should be offered virtually and free of cost to interested rural residents with funding from the Ontario government. These initiatives should be organized and advertised by rural hospitals, health centers and local health hubs to their patients and families. We hope that these initiatives will help to empower rural residents to help themselves by recognizing and intervening when a community member is having a mental health emergency.

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