the Prentice Institute
for Global Population and Economy

FCSS
Family & Community Support Services

Barons-Eureka-Warner
Family and Community Support Services
Community Needs Assessment (2024-2026)

Mental Health and Addictions

Scoping Review and Environmental Scan

A Scoping Review and Environmental Scan of Mental Health and Addictions Supports and Services in Rural Settings

Barons-Eureka-Warner Region Family and Community Support Services

Community Needs Assessment (2024-2026)

Disclaimer: No particular observation nor comment should be attributed to any specific individual, unless otherwise specified. Any errors in description or interpretation are those of the authors.

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Executive Summary

PURPOSE OF THIS REPORT

This scoping review and environmental scan is focused on the Family and Community Support Services (FCSS) provincial prevention priority of mental health and addictions. Scoping reviews are a form of knowledge synthesis, where a wide range of information about an issue is collected and summarized with the aim of creating an evidence base for practice, program, and policy decisions.

This scoping review assessed the existing research literature on recent mental health and addictions interventions in rural regions of Canada. To help contextualize the scoping review results, an environmental scan was conducted to assess the landscape of mental health supports, services, programs and policies relevant to residents of the BEW-FCSS region. The environmental scan begins with an overview of mental health and addictions in Canada, Alberta, and the BEW region using available prevalence data, followed by a summary of existing mental health-related supports for residents of the BEW region from local, regional, provincial, and federal organizations.

This scoping review and environmental scan is a part of a larger community needs assessment study conducted in partnership between the Prentice Institute for Global Population and Economy (University of Lethbridge), Barons-Eureka-Warner (BEW) Family and Community Support Services (FCSS), and the 16 municipalities that participate in and support BEW-FCSS programming. A total of five reviews and scans were conducted targeting each of the FCSS provincial prevention priorities: (1) homelessness and housing insecurity; (2) mental health and addictions; (3) family and sexual violence across the lifespan; (4) employment; and (5) aging well in community. This work provides important background information as well as ideas for potential pathways forward in the planning, design, implementation, and evaluation of preventative social services in the BEW-FCSS region.

BACKGROUND ON MENTAL HEALTH IN RURAL CANADA

Mental health and addictions (MHA) supports and service accessibility has been a long-standing issue in Canada, especially for people who live in rural areas.[1] In an effort to improve service accessibility, communities across the country have adopted some combination of providing services through primary and acute health care settings, crisis intervention teams, non-government organization initiatives, telehealth and online supports, and community-based networks.[2,3] Gaps in services, however, continue to be prevalent, and people living in rural areas tend to experience more pronounced negative effects from MHA challenges than people in urban areas.[4]

During a time of intensified MHA crises, austerity budgets, high inflation, and in many regions, a rapidly aging and slow-growing or even declining population, **rural municipalities and service organizations across Alberta are experiencing an imbalance between available resources and service user demands when it comes to the provision of MHA supports and services.** In many communities, social service centres have become the catch-all office for people seeking support for MHA issues, as well as help with income, food, shelter, domestic abuse, and crime.[2]

The Alberta Mental Health and Addictions Advisory Council, established by the Government of Alberta in 2019, conducted an assessment of the province's mental healthcare system and identified the following issues:

- **Chronic underfunding of community-based supports.**
- **Ongoing impacts of the covid-19 pandemic (e.g., financial strain, isolation, opioid addictions).**
- **User difficulties in navigating the healthcare system.**

Following from their assessment, the Council recommended a shift from a focus on acute mental health care towards long-term management, where mental illness and addictions may require the same level of consideration as other chronic illnesses (e.g. prevention-focused programming, supported referrals, co-decision making with clients, multi-sector care, reducing stigma).

The federal government has also recently acknowledged unique challenges in rural MHA program design, delivery, and evaluation.[3] There are major and long-standing gaps in data collection and monitoring when it comes to MHA programs in rural settings, limiting our collective capacity to develop rural-focused solutions. To address these challenges, prevent siloing of success stories, and aid in strategic planning, it is helpful to regularly assess what is known about MHA interventions in rural settings.

SCOPING REVIEW RESULTS

The State of Research Knowledge on Mental Health and Addictions in Rural Canada

Across the collected literature, the majority of MHA research in rural settings has:

- Focused on programs for the whole population and/or low-to-moderate needs clients, rather than high-need or complex clients.
- Focused on service description rather than strategic planning.
- Focused on virtual services (e-mental health) or hybrid programs.
- Highlighted serious gaps in data collection and monitoring in rural communities.

Key Facilitators and Barriers to Action on Mental Health and Addictions in Rural Canada

1. **Supporting the rural labour market to ensure adequate health and social service professional capacity:** The review results highlight a major theme of persistent challenges in rural MHA service provision. In the examples highlighted in this review, from implementation of new government policies, service delivery pilot programs, and multidisciplinary care system integration, **ensuring adequate human capital (e.g., adequate staffing, training, and available service hours) was identified as a key barrier to achieving desired outcomes.** Rural service providers report higher-than-average levels of professional isolation, role confusion, distress, burnout, and earlier exits from the public system. To attract and retain workers, rural communities should first assess what factors are affecting labour supply and demand in their region. These factors might include housing supply and affordability, availability of childcare, presence of peer support workers and crisis intervention teams, consistency of program funding, capacity for co-located services, and quality of IT support.

2. **Engagement in systematic and longitudinal rural-specific data monitoring practices to contribute to the development of rural-designed care models:** Despite gaps in systematic and longitudinal rural-specific data monitoring, there is a growing body of evidence[11,12] to support investment in community-centred, multidisciplinary services in rural Canada to reduce care delays, demand on psychologist and emergency services, and hospitalizations. There have already been efforts made in some communities to better integrate MHA care with the existing healthcare system (e.g., Situation Roundtables). Unfortunately, due to a number of resource constraints (e.g., short-term funding, inflexible funding criteria) it is not a widespread practice in healthcare systems to consistently include mental health professionals on healthcare teams, nor rural service providers in urban-based professional support networks. **Key facilitators to the success of multidisciplinary services have included: (1) the inclusion of school board representatives, social and victim services, probation officers, child welfare workers, and nearby urban-based providers; (2) having strong leadership that consistently prioritizes the provision of inclusive, adaptive, and timely care; and (3) holding in-person meetings t**o address community challenges and align responses strategically.

3. **Ensuring ease in system navigation for both providers and clients:** Along with labour and service design considerations, the third major theme to emerge from our analysis was a need to support system navigation for rural service providers and clients, particularly in the form of digital technology supports. High-speed internet coverage in rural areas of Canada has steadily improved, albeit at a slower pace than projected by the Canadian Radio-television and Telecommunications Commission **(**CRTC).[13] To address the rural digital divide, recommendations from the Canadian private sector have included:

    - Government subsidies to incentivize internet service providers to invest in rural infrastructure development.
    - Utilization of fixed wireless internet technology.
    - Local collaborations to explore alternative solutions like community-owned networks.
    - Policies aimed at promoting competition among internet service providers.

Once a rural area has attained adequate connectivity for accessing digital and virtual MHA services, both service providers and service users may require ongoing support to make optimal use of available resources. **Some of our collected literature found that rural service providers were less likely to adopt new digital tools into their practice due to a lack of perceived readiness, misalignment with their local processes, and privacy concerns. They were also often struggling to maintain a reasonable workload given the compounding effects of their expanded scope of practice, administrative tasks, and workplace gaps in digital technology and IT support.** The MHCC has made some efforts to address these issues in the creation of an implementation readiness tool for service providers to navigate their E-mental health options, as well as highlighting the benefits of system user navigation sites (e.g., Head to Health) in their new e-mental health strategy.

Major Themes in Rural Mental Health Intervention Research

The review results were structured using a tiered approach adapted from the Canadian Centre on Substance Use and Addiction and the National Treatment Strategy Working Group.[11]The tiers represent a continuum of MHA supports and services. One client may access several tiers in their care journey as their needs become better recognized by service providers and as they evolve over time. In a given region, there are usually resource links between the different tiers of services (e.g., a primary care provider may provide both Tier 2 and 5 services in their practice), supporting client transitions between them.

Tier 1: Health promotion and illness prevention (Whole population): Broad efforts that draw on natural systems and networks of support for individuals, families, and communities. They provide a foundation for a healthy population, and have broad eligibility criteria, allowing anyone to access them. Examples of Tier 1 interventions identified by this review included mental health literacy programs (both community- and school-based) to address MHA stigma and low public awareness.

Tier 2: Screening and initial assessment intervention (Low needs): Supports and services considered Tier 2 are screening services, short-term interventions, and referrals, and can be offered in primary, emergency, and public health settings, as well as social service and employment programs. Examples of Tier 2 interventions identified by this review included general practitioner training programs to expand their mental healthcare scope, clinic-based outpatient addictions treatment programs, and e-mental health resources.

Tier 3: Community-based, outreach, social support, and rapid-access services (Moderate needs): Supports and services considered Tier 3 are active outreach, risk management, and basic assessment and referral services (e.g., outpatient counselling, home-based management, supervised injection sites). Examples of Tier 3 interventions identified by this review included mobile clinics, school-based referral programs, and outreach programs for farmers and their families.

Tiers 4 and 5 (intensive and long-term interventions): Not typically offered in rural communities of Canada unless through telehealth or virtual modalities.

ENVIRONMENTAL SCAN OF MENTAL HEALTH AND ADDICTIONS IN THE BEW REGION

State of Mental Health and Addictions in the BEW Region

In 2023, Alberta Health Services conducted a province-wide Community Health Survey. The survey's results are available through a public dashboard down to the Zone and County level (AHS, 2024). **For many of the survey questions about mental health, the BEW region counties (M.D. of Taber, County of Lethbridge, and County of Warner) had comparable results to provincial averages** (e.g., overall perceived quality of life, experiences of bullying and assault, school failure, financial crises, work problems such as demotions and pay cuts, work stress, housing insecurity, reported screen time, and smoking habits). Notable differences among BEW region results are summarized in Table 1 below (Alberta Health Services, 2023).

Table 1. BEW Results from the Alberta Health Services Community Health Survey, 2023

Survey Measurement	Notable BEW Region Results
Good Neighbour Relations (Yes)	**BEW region (90%)** South Zone and Province (82%)
Feeling a Part of a Community (Yes)	**County of Lethbridge (90.1%)** Province (82.1%)
Volunteerism (Yes)	**BEW region (53.7-58.5%)** Province (44.2%)
Work Stress (Yes)	**County of Lethbridge (31.7%)** BEW region (23.2%)
Alcohol Use (Yes)	**County of Warner (57.5%)** **M.D. of Taber (58.7%)** Province (76.2%)
Spiritual Health (Satisfied)	**M.D. of Taber (90.9%)** Province (79.2%)

(Source: Alberta Health Services. (2024). Retrieved from: https://www.healthiertogether.ca/prevention-data/alberta-community-health-dashboard/)

Local Mental Health and Addictions Supports in the BEW Region

The are several mental health service institutions and programs (acute, rehabilitation, community, and outpatient) located within the BEW region and administered through **Alberta Health Services, with most centred in Taber and Raymond.** Coaldale and Milk River also offer community and outpatient therapeutic recreation programming.

BEW Family and Community Support Services (FCSS) services provide locally driven, preventative social initiatives with the aim of promoting healthy environments and positive experiences at critical stages in development, with an emphasis on prevention, volunteerism, and

local autonomy. **While it is outside of the BEW-FCSS preventive mandate to provide direct, long-term rehabilitation or intensive treatment for mental and addictions crises, they can act as a connector, working with community organizations to help residents find and access specialized mental health and addictions services.**

Provincial and Federal Mental Health and Addictions Initiatives in Rural Areas

In 2022, the Alberta Mental Health and Addictions Advisory Council published a report outlining the province's new recovery-oriented model of mental health care: Toward an Albertan Model of Wellness: A Framework for Transformative Change. **In a recovery-oriented approach, quality of life is a guiding value, and success relies on the support and participation of schools, workplaces, police/the justice system, faith-based organizations, families and neighbours** to enable individuals challenged by mental illness and addictions to be proactively involved throughout their journey.

Within the key focus areas of the framework, prevention-oriented initiatives include:

- Development of the **Digital Overdose Response System** mobile app.
- Offer **training to police** to be able to connect individuals to recovery-oriented services.
- Expand **affordable counselling options** through a partnership with Counselling Alberta.
- Increased funding for **211 Alberta to enhance navigation services.**
- Increased support for **school-based youth mental health programs** (e.g., CASA Mental Health Classroom Program and Integrated School Support Program).
- Expanded supports at **Kickstand Centres** for youth.

Aside from the initiative to enhance 211 Alberta (a helpline for non-emergency issues in communities) services for rural populations, the word "rural" is not mentioned in the framework itself, a stark difference from the previous provincial MHA strategy, and despite there being well-known unique challenges in rural communities to delivering MHA care across a full spectrum of supports and services.

KEY MESSAGES FOR MENTAL HEALTH AND ADDICTIONS SUPPORTS IN THE BEW REGION

1. **Mental health literacy programs are an important part of supporting mental health in rural communities.**

   BEW Assets:

   - **FCSS' promotion of mental health awareness and information sharing** (e.g., healthy relationship workshops).
   - **Heartland Training & Support Hub (Farm Safety Centre):** A charitable organization that has been delivering farm safety programs to rural Albertans since 1991 and is operated through the Raymond & District Future Society.

   Potential areas for further intervention and assessment:

   - **Mental health and suicide awareness training for community members.**[3] Mental health literacy programs in rural communities have been found to be more effective when there is a focus on skill development (e.g., how to provide neighbour assistance, self-reliance tools). Alberta Health Services offers the *Community Helpers Program*, which provides information and assists community members with developing their competencies to be peer supports for those within their community experiencing mental health challenges.

2. **Multisectoral service coordination can be beneficial for building capacity in rural areas to address mental health and addictions challenges.**

   BEW Assets:

   - The region has several emergency, health, social service, and community organizational partnerships to address social challenges (e.g., **Horizon Victim Services, Safe Haven Outreach Program**) that may serve as a foundation for expanding supports for mental health and addictions.

   Potential areas for further intervention and assessment:

   - **Intersectoral meetings led by mental health counsellors to discuss case-by-case situations—known as situation tables**, inclusive of representatives from school boards, social services, police and the justice system. Meetings and collaboration were linked to a drop in police calls and emergency presentations for MHA issues in rural Ontario.[4]

3. **Co-located services can involve both physical and virtual nesting of services to address an issue, ensuring people have access to multiple services that assist with their needs.**

   BEW Assets:

   - **Health centres** in the region (i.e., Taber Health Centre, Raymond Health Centre, Milk River Health Centre, and Coaldale Health Centre) offer broad healthcare services for both physical health and acute mental health issues.
   - **Physical FCSS locations** in the region provide a range of services, including one-on-one counselling, groups for child development, seniors' activities, and immigration services.

   Potential areas for further intervention and assessment:

   - **Creating a service hub: Co-locating services can look like in-person and virtual MHA support, one-to-one and peer-based counselling, workshops, and employment supports,** all of which are programs run by the *Integrated Youth Services Network (IYS-Net) – Kickstand* (for people ages 12 to 25).[5] The IYS-Net utilizes a co-located model to address mental health and other needs of youth, with 160 sites across Canada, soon to be 7 in Alberta, including Bonnyville, Drayton Valley, Strathmore, and Medicine Hat.

4. **Adapting healthcare systems entails promoting alternative and better-suited modes for care for people experiencing mental health and addiction challenges.**

   BEW Assets:

   - **Online services and telemental health services,** including crisis hotlines, are available in the BEW region, increasing the modes of access to mental health services in the communities.

   Potential areas for further intervention and assessment:

   - **Rural Outpatient Opioid Treatment** in rural Ontario is a program that integrates opioid treatment into primary care settings, offering group recovery, peer support, and opioid agonist therapy.[6] Adaptations to the health care system, such as those through the Rural Opioid Outpatient Treatment program, can support holistic approaches to healthcare and reduce stigma around MHA challenges.

5. **Mobile crisis and rapid-access care models can meet the on-demand mental health and addictions needs of a community where specialized services may not be consistently available.**

   BEW Assets:

   - The **RCMP or police are often the first responders to crises** in communities, although there are concerns among residents about the timely response and appropriateness of police services responding to mental health and/or addictions crises.
   - **Crisis hotlines** can offer remote and private services for mental health crises and suicidality.
   - **Health centres and Recovery Alberta** (Alberta Health Services) provide acute and specialized care to people experiencing mental health and addiction crises, respectively.

   Potential areas for further intervention and assessment:

   - Rapid-Access Addictions Medicine (Manitoba).[7]
   - Co-responder teams (police and MHA professionals) (Ontario).[8]
   - Mobile youth crisis service (Ontario).[9]
   - Peer-led overdose training (Quebec).[10]

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Scoping Review

Mental Health and Addictions

1.0. Introduction

From 2024 to 2026, the Prentice Institute for Global Population and Economy at the University of Lethbridge was contracted by Family and Community Support Services (FCSS) to conduct a Needs Assessment in the Barons-Eureka-Warner (BEW) region. The purpose of this project was to empower the 16 municipalities within the BEW region of southern Alberta to make informed decisions about how they invest in their communities, provide social services, and engage with other municipalities. Part of this project involved completing scoping reviews that covered each of the five priorities identified in the Government of Alberta's FCSS Accountability Framework (2022). These priorities include homelessness and housing insecurity, mental health and addictions, employment, family and sexual violence across the lifespan, and aging well in community (Government of Alberta, 2022).

The five Provincial Prevention Priorities are intertwined, setting a precedent for an integrated approach to prevention and social policy. This scoping review focuses on the state of strategies to support mental health in rural areas of Canada, specifically to better understand the different factors that contribute to intervention success or failure. From existing academic and grey research literature, this work aims to identify potential evidence-informed policy directions and recommendations that operate within and across the FCSS provincial prevention priority of mental health and addictions.

1.1. Scoping Review Objectives

This review focuses on the provincial prevention priority of mental health and addictions, aiming to identify, synthesize, and document trends within the extant academic and grey literature on mental health and addictions supports in rural settings. First, we provide background on key concepts and definitions, the intersectional nature of mental health dynamics, and the context of rural mental health and addictions support in Canada. Second, we outline the scoping review research methodology, including how we identified and selected relevant studies. Third, we discuss the results of the data extraction based on an analysis of the selected literature to determine key themes and explore notable interventions and their outcomes. Fourth, we outline the key facilitators and barriers to mental health interventions. Fifth, we conducted an environmental scan of mental health supports for residents of rural Alberta and the BEW region. We then provide a discussion and conclusion including potential future directions for policy, practice, and research in addressing mental health challenges in rural communities of the BEW region.

The objectives of this scoping review were to:

1. Provide an overview of academic and grey literature on mental health and addictions supports and strategies in rural Canada.
2. Identify strengths and gaps in the quantitative and qualitative literature assessing the impacts of mental health support strategies in rural Canada.
3. Identify and recommend promising interventions in rural communities to promote mental health based on existing literature.

Given Canada's dynamic cultural, socioeconomic, and political landscape, it is beneficial to engage in regular reviews of MHA research to highlight emerging policies, practices, and outcomes and ultimately inform systemic responses for key populations. Recent MHA service reviews inclusive of the rural Canadian context have included a 2018 review of nine psychiatry-centric programs across the country (Letto et al.), a 2019 narrative review of psychiatric care (Friesen), and a 2024 short-form literature review published in AIDE Canada (Masse et al., 2024). Our scoping review is wide in its catchment of MHA supports and services (those independent of psychiatric services) and is meant to provide a comprehensive overview of recently evaluated MHA interventions in rural communities of Canada, known facilitators and barriers to intervention success, and future directions for MHA service research.

Although the project is conducted in collaboration with the FCSS and researchers are situated in close geographical proximity to the BEW region, it is still vital to practice reflexivity. Practicing reflexivity entails understanding the power dynamics that exist within the research field, such as those between researchers and participants. **This review does not serve as a rule book for what should be done, but rather it provides evidence for what strategies exist within rural mental health and addictions services and a tool that communities can *choose* to use**. We intend to provide what Van Assche et al. (2016) identify as "second order observation: outsiders show the

community how to take a step back, to see how local actors have been thinking about the community in the past…This external perspective sheds new light on the present" (p. 64).

2.0. Background

In Canada, mental health and addictions (MHA) services are primarily the responsibility of provincial and territorial governments, funded in part by the federal government through the Canada Health Transfer, resulting in a heterogenous landscape of MHA care across the country. In the face of intensified MHA challenges among the general population since 2020, with the prevalence of moderate and severe mental illness symptoms persisting above pre-pandemic levels (CAMIMH, 2024), governments and associations across Canada have piloted innovative MHA care models (e.g., Integrated Youth Services Network), engaged in knowledge mobilization activities, and considered new policy resolutions which target specific MHA concerns (e.g., see SARM, 2023). The Canadian Mental Health Association (CMHA) and the Mental Health Commission of Canada (MHCC) released updated national mental health strategies (e.g., e-mental health, MHCC, 2024) and reports highlighting new and promising MHA interventions in each province and territory (CMHA, 2024). These developments suggest a growing momentum in improving availability, accessibility, and effectiveness of MHA care across Canada. However, mental health advocates have continued to raise long-standing concerns about gaps in MHA care, particularly within areas of funding, preventative approaches, and long-term care management.

The 2024 Canadian federal budget includes MHA services as one of four top priorities for health funding (Department of Finance Canada, 2024; SARM, 2023). However, MHA services are not fully included in Canada's universal health care system. Under the Canada Health Act (1984), MHA services are publicly funded if provided by physicians and hospitals, while services from other providers (counsellors, psychotherapists, peer support workers, and social workers) are excluded. Field experts have raised the question (e.g., Barker et al., 2023): To what extent should mental health care be publicly funded? The CMHA has called for reforms to the Canada Health Act, or a new law altogether, to include MHA care in the public system and supported on par with physical health (CMHA, 2024)

In addition to a limited scope for the allocation of federal funds towards MHA care, there is also no minimum percentage of federal funds (Canada Health Transfer and Canada Social Transfer) that provincial and territorial governments must use for MHA supports and services, which advocates have critiqued as being chronically underfunded and difficult to access (CAMIMH, 2024; Zafar, 2024). A November 2024 CMHA review found that provinces and territories contribute an average of 6.3% of their total healthcare budget to MHA services (a proportion that has decreased over time), when the CMHA recommends 12% and Western European nations allocate 9-15% (CMHA, 2024; Zafar, 2024). MHA underfunding at the provincial/territorial level is of particular concern given that the federal government recently terminated a national MHA care

program and, in the process, re-emphasized the responsibility of provinces and territories to support the MHA care needs of their communities.

In 2020, Health Canada implemented the Wellness Together Canada portal which provided 24/7 access to virtual MHA care. The initiative was considered successful in terms of user retention, reported symptom improvement, and financial savings due to emergency prevention (CAMIMH, 2024). In terminating the program in 2024, Health Canada stated, “the emergency part of the global pandemic is over, [and] provinces and territories are best placed to support the mental health and substance use needs of their communities” (Zafar, 2024, paragraph 5). However, in all three years (2022 to 2024) of the Canadian Alliance on Mental Illness and Mental Health report card, a nationally representative survey sample of Canadian adults gave all 10 provinces a grade of D or F for their MHA services (CAMIMH, 2025).

2.1. Mental Health and Addictions Support in Rural Canada

In Canada, approximately 15% of the population lives in rural areas, which Statistics Canada defines as areas with a population density of fewer than 400 persons per square kilometre (Statistics Canada, 2022). For rural residents, certain adversities, including mental illness and addiction, housing and food insecurity, and experiences of discrimination and violence, are more pronounced given gaps in appropriate local supports and services (Government of Canada, 2024). In 2024, the Canadian federal government, the CMHA and the MHCC acknowledged unique challenges in rural MHA care design, delivery, and evaluation, including geographic isolation, lower levels of education, and disproportionate impacts of poverty due to service gaps (CMHA, 2024; Government of Canada, 2024).

One of the most significant barriers to MHA care in rural Canada is geographic isolation. Rural communities are often spread sparsely, and many residents live far from facilities that provide MHA services, especially for higher or complex needs, making it difficult to access community support and orthodox MHA services when needed. Rural isolation is compounded by limited and/or costly transportation options, as well as mental health stigma, which can hinder individuals from seeking care (Coombs et al., 2021; Kreitzer et al., 2016; Murney et al., 2020). Socioeconomic factors also play a crucial role in the accessibility of MHA services, as rural areas of Canada tend to have higher rates of poverty and lower levels of education compared to urban centers, which can increase the risk of mental health problems and reduce the likelihood of seeking care (Morales et al., 2020).

Many rural areas in Canada face a critical shortage of MHA professionals, including psychiatrists, psychologists, and social workers (Moroz et al., 2020). These constraints have resulted in long wait times and limited access to specialized care for rural residents, further exacerbating MHA problems. Rural professional labour shortages are complex in nature, rooted in social, cultural, economic, systemic, and political dynamics. For example, provincial healthcare and social program funding models in Canada have been criticized by mental health advocates and researchers for inadequate consideration of higher costs in providing services to rural areas due to

their geographic isolation, and so the same funding algorithm applied to urban and rural areas disadvantages rural communities and limits their labour demand capacity (Masse et al., 2023).

Rural service providers have also voiced concerns about systemic issues in MHA care that are exacerbated within the rural context, including an imbalance between job resources and job demands for staff and inflexible referral and scheduling processes that can hinder access to urban-based services (Barker et al., 2023; Glover, 2023). For example, in Ontario, some MHA formal referral systems do not take geographic location into account nor the service limitations of a referring provider, resulting in disproportionate care delays for rural clients who have limited alternative options (Glover, 2023). Rural clients in Ontario are also removed from care lists after three missed appointments, even if their absence was due to inclement weather impeding travel, transportation difficulties over a long distance, or poor cellular service resulting in missed phone calls. These examples illustrate how MHA policy can be insensitive to rural realities. The need for improved MHA data collection and monitoring in rural Canada has been highlighted by both the CMHA and MHCC in order to better inform decision-making (CMHA, 2024; MHCC, 2012). In addition, some rural local and regional authorities in Ontario have also made explicit calls for more involvement in health and social service planning so they can advocate for equitable access for their residents, as well as suggest local resources and existing networks to aid in service expansion (ROMA, 2024).

Rural communities are under pressure to maintain existing MHA supports and services during a time of provincial austerity budgets, high inflation, and in many regions a rapidly aging and slow-growing or even declining population. In many of these communities, given a lack of specialized MHA services, social service centres can become the catch-all office for community members seeking support for MHA issues as well as help with income, food, shelter, domestic abuse, and crime (Bellefontaine, 2023). For example, in Alberta, Family and Community Support Services (FCSS) is a joint provincial-municipal funding program designed to establish and operate social services with an emphasis on prevention and local autonomy. In a 2023 survey of rural FCSS directors, 95% reported increased pressure since 20 18 to provide services beyond prevention, and 79% said they felt that their FCSS programs were having to take on responsibilities that were meant to be the mandate of other provincial ministries or agencies (Banack et al., 2023). Almost half of the directors surveyed reported that given gaps in provincial funding, their municipal government had had to increase their contribution by over 75% to support their local FCSS in maintaining services. In 2024, the provincial government announced a 10% funding increase to an FCSS major partner program, Family Resource Networks, but service providers continued to voice concern about underfunding, long waitlists, and delayed care (Cummings, 2024; O'Nyons, 2024).

Considering these resource challenges in MHA care across Canada, with rural communities experiencing disproportionate gaps in services compared to urban communities, there is a need to regularly assess our collective body of knowledge regarding MHA interventions in rural settings in order to prevent siloing of success stories and to support geographical equity in MHA policy design, implementation, and evaluation.

3.0. Scoping Review Methodology

We utilized Arksey and O'Malley's (2005) framework for scoping reviews to assess the extant academic and grey literature on homelessness and housing insecurity. In their work, Arksey and O'Malley outline their process for completing a scoping review:

1. Identifying the research question
2. Identifying relevant studies
3. Study selection
4. Charting the data
5. Collating, summarizing, and reporting the results (Arksey & O'Malley, 2005, p.22)

3.1. Identifying the Research Questions

Guided by the Provincial Prevention Priorities outlined in the FCSS Accountability Framework from the Government of Alberta (2022b), the literature review is focused on the prevention priority: mental health and addictions As such, we are interested in questions regarding interventions for mental health and addictions in rural settings similar to the BEW-FCSS region. Our research questions for this scoping review were:

1. What MHA supports and services are available in rural Canada?
2. What are the facilitators and barriers to their delivery?
3. What supporting evidence is there to demonstrate positive outcomes from a given support or service?

3.2. Identifying Relevant Studies

3.2.1. Eligibility Criteria

The scope of this review was broad, covering the extent and nature of literature on available mental health supports and services, barriers and facilitators to accessing and utilizing these services, and their effectiveness in rural communities in Canada. Articles were included if they met the following criteria:

- They included individuals with a diagnosed mental or substance use disorder, those who experienced mental health or addiction issues, and/or individuals who were part of a mental health community service. Alternatively, they included healthcare providers who offered diagnostic, assessment, or treatment services for mental health or addiction issues.
- They discussed obstacles that impeded the uptake, quality, or level of mental health or addiction services or described facilitators that supported the uptake, quality, or level of services received.

- They included service users, healthcare providers, or services based in rural Canada and evaluated the effectiveness of available mental health or addiction programs.

The population/concept/context (PCC) framework guided the selection of the eligibility criteria (Kavanagh et al., 2023). This review included mental health and addiction programs evaluated for their effectiveness, articles that pooled results across participants from metropolitan and rural areas, and articles that reported on the barriers and/or facilitators of specific rural mental health service implementations or service models. Articles were excluded if they did not provide sufficient detail to describe barriers or facilitators to accessing or utilizing services, or if they focused solely on large metropolitan areas without a rural comparison. We also did not include literature focused on remote communities only. This review was conducted as a part of a larger study of a southern rural region of Alberta with most of the study communities considered less or moderately remote (Statistics Canada, 2022), and thus our aims were to understand rural-specific solutions to MHA care delivery challenges.

3.2.2. Defining Rural

As this review focuses on the rural context surrounding interventions for and prevention of different social challenges (homelessness and housing insecurity, mental health and addictions, employment, family and sexual violence across the lifespan, and aging well in community), it is important to acknowledge the complexities that arise when trying to define *rural* within the Canadian context. The definition of rural varies across political institutions and organizations, with several scaled measurements of rurality used within Canada (Hallstrom et al., 2015). Generally, a community with low population density (e.g., towns, villages, hamlets) and high distance to an urban centre is considered rural. Statistics Canada and the Government of Canada rely on measurable dimensions to define rural areas, such as population size and density (Statistics Canada, 2022).

However, some authors' definitions of rural areas are more nuanced to include how people view themselves in rural contexts, including considering feelings related to rurality and community (Reimer & Bollman, 2010). Multiple dynamics, including geographic and sentimental, affect how rural is perceived and defined. Instead of having a discrete and conclusive category of rural, Reimer and Bollman (2010) offer that rurality exists on a spectrum of these dynamics, where it cannot be defined solely by population size/density or geographic location. Instead, they suggest that rural areas are defined by different degrees of rural, accounting for factors such as the presence of employment opportunities and proximity to urban areas (Reimer & Bollman, 2010).

3.2.3. Search String Development and Literature Sources

We searched the CINAHL (EBSCO), APA PsycINFO (Ovid), MEDLINE (Ovid), and Social Services Abstracts databases (ProQuest), as well as the websites of Canadian federal and provincial departments of health, including the Alberta Health Services (AHS), Centre for Addiction and Mental Health (CAMH), Canadian Mental Health Association (CMHA), First

Nations and Inuit Health Branch (FNIHB), Mental Health Commission of Canada (MHCC), and others. The academic literature search was conducted in July 2024, with a date filter applied from 2014 to the present. The grey literature search was conducted in October 2024. Additional sources were identified through "snowball" searches of included studies.

3.2.4. Study Selection

The search strategy was developed by OKO and HCA in consultation with a librarian. Elements of search strings from previously published scoping reviews with a similar scope to our study were utilized (Kavanagh et al., 2023). The search strategy was first developed for MEDLINE and then adapted for the other three databases. Supplementary File 1 shows the search strategy for all the databases and a list of the grey literature sources. When available, medical subject headings (MeSH) from controlled vocabularies were used in the search. The search sensitivity was enhanced by entering concepts in the search string as keywords with truncation (*), proximity operators (adj), and expanders (exp/) used when appropriate while Boolean operators connected subject headings and keywords.

For the academic literature search, one reviewer (OKO) applied the search strategy to the databases and websites. The retrieved articles' bibliographic information was imported into Zotero version 7 software for deduplication. After deduplication, the articles were exported to Rayyan, a systematic review management software and screened in two phases: title/abstract and full-text screening. Two independent reviewers (HCA and OKO) completed the academic article screening and data extraction. In cases where there were discrepancies regarding the eligibility of an article, a meeting was held to reach a consensus. For the grey literature search, authors CH and SA applied the search strategy to search engines including Google Scholar as well as any mental health and addictions-focused webpages found during the environmental scan.

The academic literature search across four databases yielded 2,257 results, of which 733 duplicates were removed, and 1,434 articles were removed that did not meet the inclusion criteria. After removing ineligible articles, 90 were eligible for review, four of which could not be retrieved through the library's collection or interlibrary loan, totalling a final 86 eligible articles for review. The 86 retrieved full texts were assessed, and 51 were selected for analysis. No additional articles were found by hand-searching their references. A total of 64 grey literature documents were collected, including institutional and technical reports, dissertations, evidence and policy briefs, white papers, strategy documents, news articles, and expert opinions. Across academic and grey literatures, we analyzed a total of 115 documents in this review (Figure 1).

3.2.5. Charting the Data

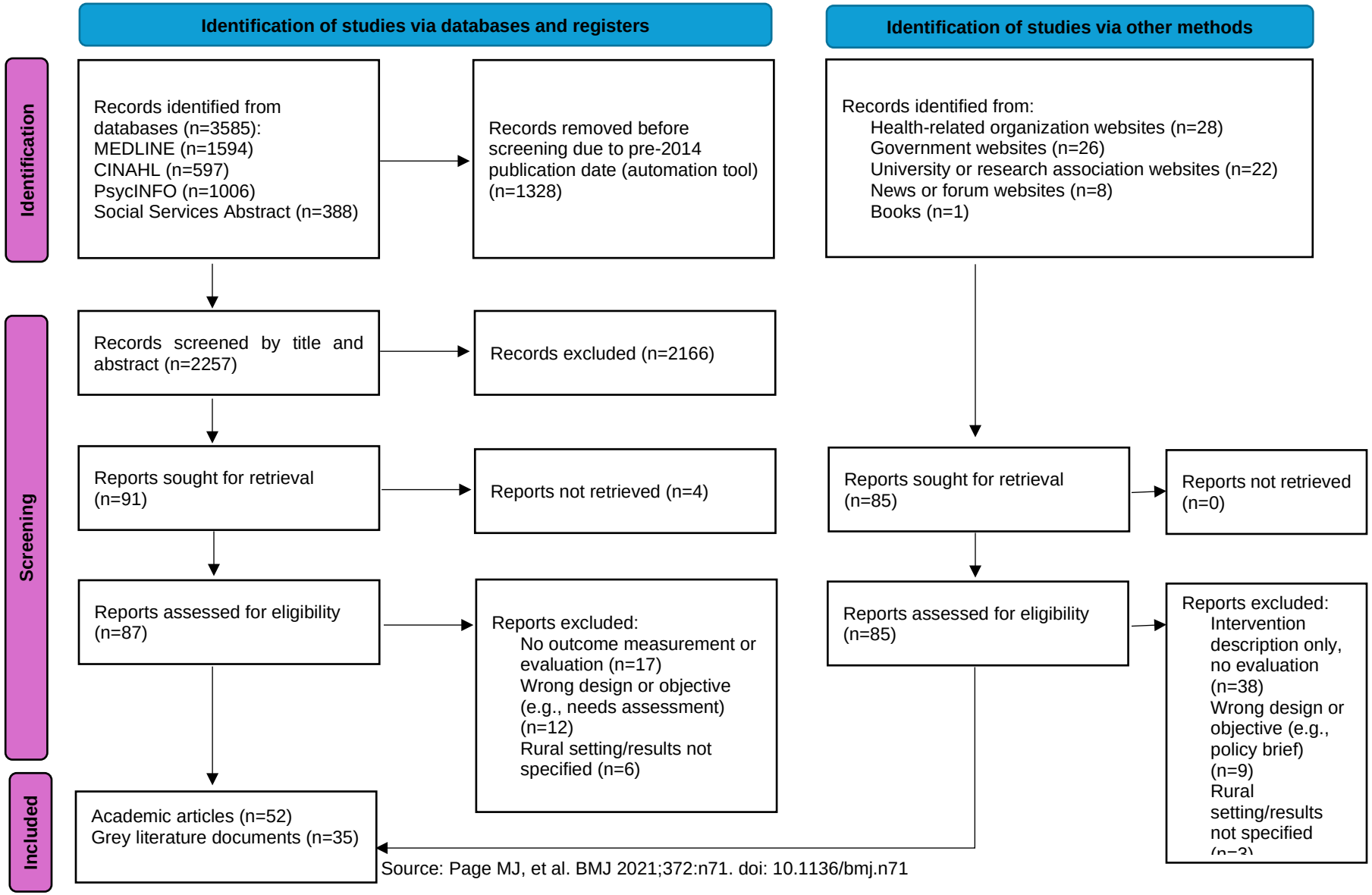
To ensure consistency with the research question, a data charting form was developed and piloted by two authors (OKO and HCA). One author (OKO) then charted the data for each of the eligible articles using Microsoft Excel and the second reviewer (HCA) reviewed the final chart for accuracy. The following data items were extracted from eligible studies: author and year, study

objective, study design, name and description of the mental health or addiction service or program, location (specific rural community and province), barriers, facilitators, effectiveness, rural area of Canada, and summary of findings. For studies that included participants from both metropolitan and rural areas, only data pertaining to those from rural areas were extracted, except in instances where statistical differences between groups were reported for comparison. Similarly, for articles that included both eligible participants (e.g., healthcare providers) and ineligible participants (e.g., individuals without evidence of engagement with services), only data from eligible participants were extracted.

3.2.6. Collating, Summarizing, and Reporting the Results

Descriptive statistics (frequency and percentage) were used for the presentation of the literature characteristics. A narrative synthesis of the extracted data was conducted in line with the three research questions (see above).

Figure 1. PRISMA Flow Diagram of Study Selection



4.0. Scoping Review Results

We have chosen to use a tiered model to structure our review results, as this approach to MHA services has been adopted by several organizations and regions in Canada (e.g., Canadian Centre on Substance Abuse, Alberta Health Services, Mental Health Commission of Canada) (Government of Alberta, 2011; Letto et al., 2018; MHCC, 2019). The tiers are as follows:

- Tier 1: Health promotion and illness prevention for the whole population
- Tier 2: Screening and initial assessment/intervention for low needs clients
- Tier 3: Community, outreach, social support, and crisis and emergency services for moderate needs clients
- Tier 4: Intensive community, acute, and short-term services for high-needs clients
- Tier 5: Long-term, specialized, and justice-related services for complex needs clients

These tiers represent a continuum of MHA supports and services. One client may access several tiers in their care journey as their needs are better recognized and as they evolve over time. In a given region, there are usually resource links between the different tiers of services (e.g., a primary care provider may provide both Tier 2 and 5 services in their practice), supporting client transitions between them. Given that Tier 4 and 5 services are not typically offered in rural communities of Canada unless through telehealth or virtual modalities, we lump these services together in the E-Mental Health section of the results.

4.1. Included Literature Characteristics

Thirty-two of the selected academic articles discussed mental health intervention services and programs, 13 focused on addiction and substance use, and 6 covered both topics. Nine of the articles addressed multiple Canadian provinces, while the remaining articles focused on specific provinces: Manitoba (1), New Brunswick (1), Newfoundland and Labrador (1), Northwest Territories (1), Nova Scotia (1), Saskatchewan (1), Territory of Nunavut (2), Québec (3), Alberta (5), British Columbia (5), and Ontario (21).

Most of the academic articles (n=42, 82.4%) discussed physical or hybrid physical and virtual programs and services, while 9 (17.6%) focused solely on virtual programs. 4 articles were focused on rural Alberta, 29 covered rural Canada outside Alberta, and 18 included both rural and urban areas. Of the articles, 34 (66.7%) described available programs and services, while 17 (33.3%) examined the effectiveness of these services.

4.1.1. Included Literature: Geography and Publication Dates

The majority of articles had a national focus (n=23) or were reporting on studies that took place in Ontario (n=25). The next most common study locations were in Alberta (n=11) and British Columbia (n=8). Other study locations included Quebec (n=3), Newfoundland & Labrador (n=3), New Brunswick (n=2), Manitoba (n=2), Nunavut (n=2), Saskatchewan (n=1), Nova Scotia (n=1), and the Northwest Territories (n=1). In terms of publication date, most included articles were published between 2019 and 2024 (n=69) (Figure 2).

4.1.2. Included Literature: Research Methods Used

Study designs within the included articles were qualitative (interviews, focus groups, and case studies), quantitative (survey collection and analysis), combined or mixed methods (utilizing one or more qualitative and quantitative methods), clinical trials, secondary data collection and analysis, and literature/scoping reviews (Figure 3). Table 2 charts the designs used in the literature, identifying how many used each type of design. Table 3 provides greater detail of the methods used in the literature. The categories in Table 3 are non-exclusive, where one study can be reflected in multiple method categories.

Table 2. Study Designs of Included Articles

	Study Designs				
	Qualitative	Quantitative	Combined/ Mixed Methods	Clinical Trial/Program Evaluation	Literature/ Scoping Review
Number of Studies	25	10	8	2	4

Table 3. Included Articles' Data Collection Methods (non-exclusive)

Study Methods	**Number of Studies**
Interviews	24
Focus Groups/Workshops	10
Combined/Mixed Methods Research	8
Surveys	8
Case Study	5
Statistical Analysis of Secondary Data	4
Literature/Scoping/Systematic Review	4
Participatory Action Research/Community-engaged Research	4
Content Analysis	2
Clinical Trial/Program Evaluation	2
Community Mapping	2
Participant Observation	1
Indigenous Methodologies	1

Figure 2. Included Articles by Study Location

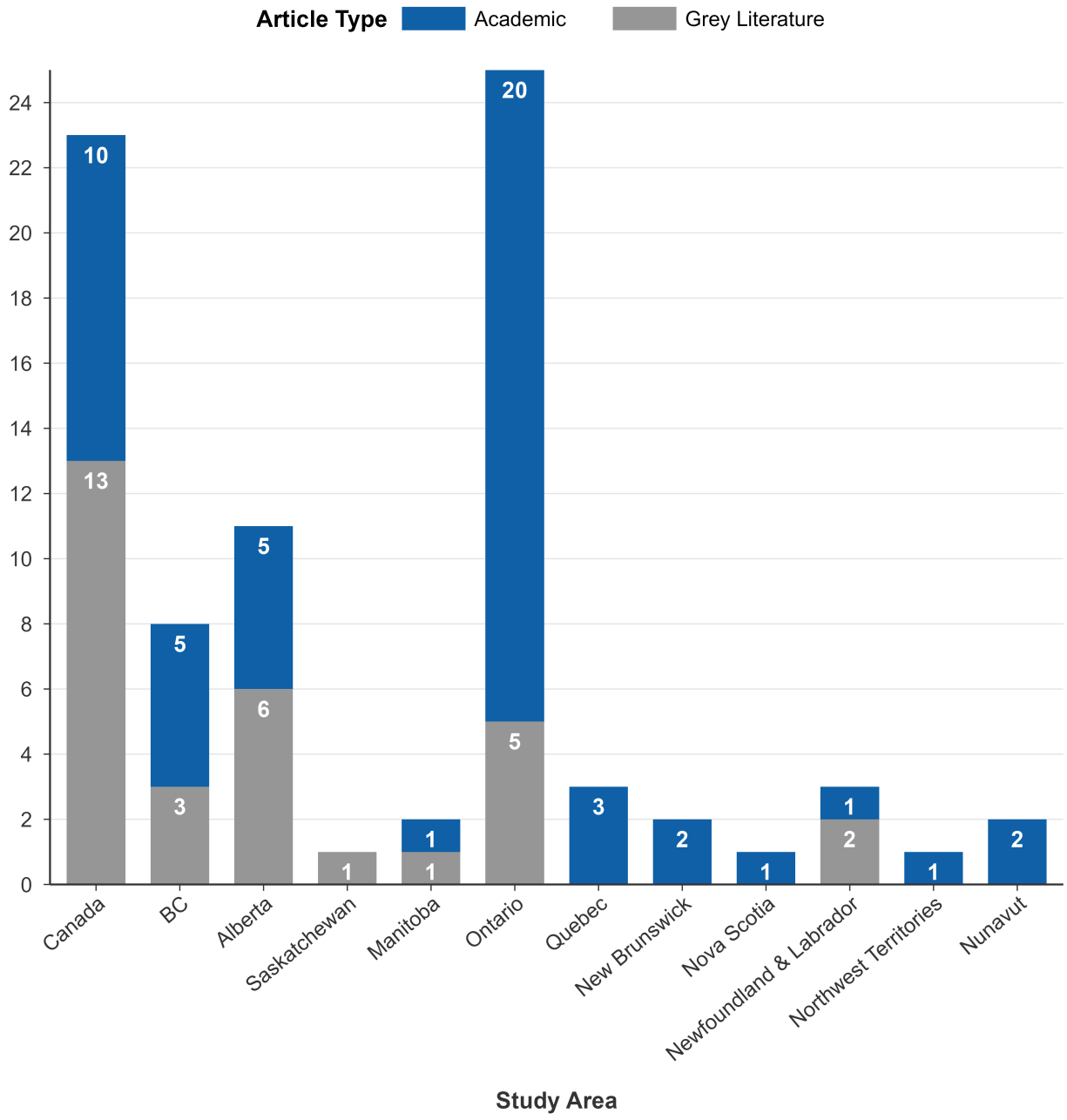
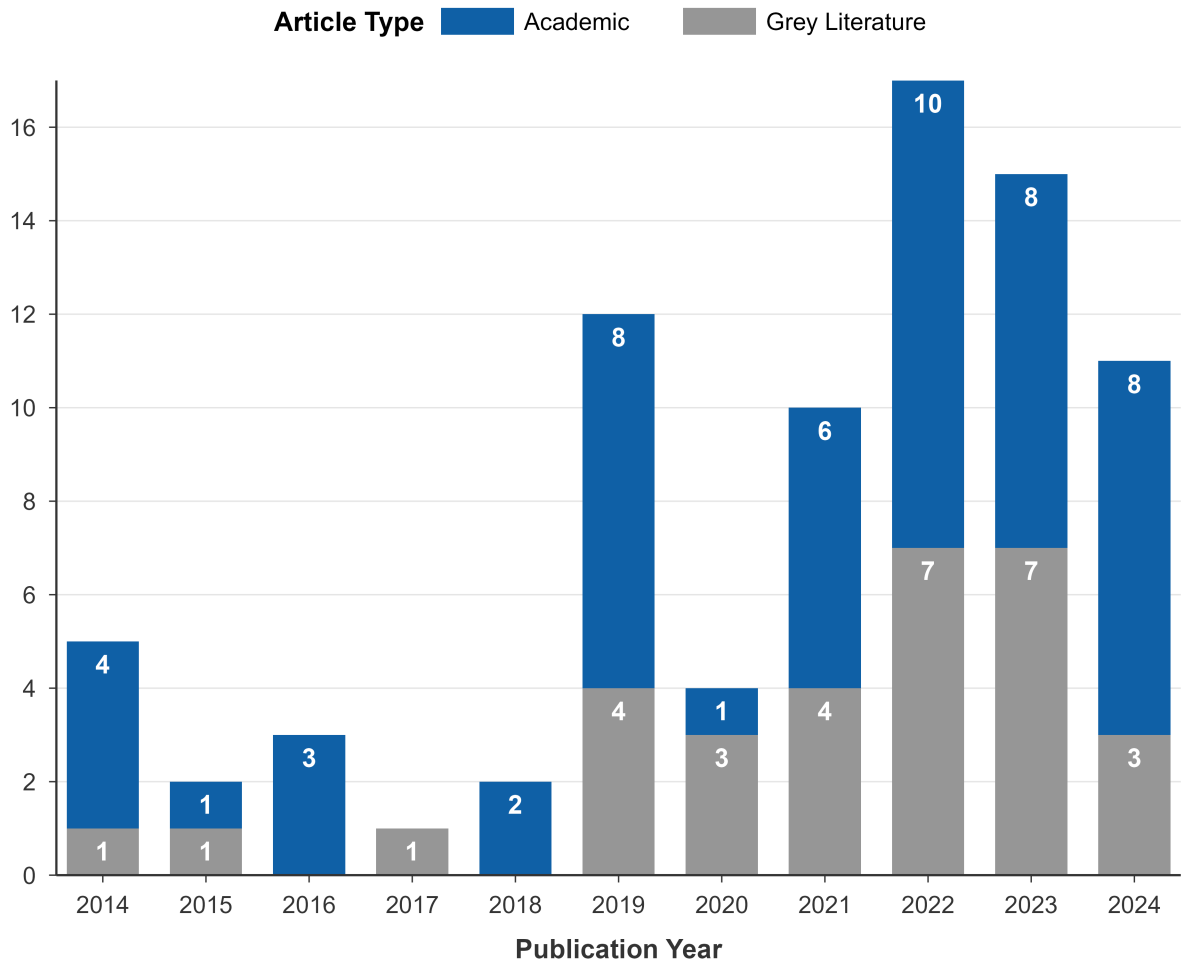


Figure 3. Included Articles by Publication Year



Note: Four grey literature articles did not have publication dates

4.2. Key Facilitators and Barriers to Intervention Success

4.2.1. Supporting the Rural Labour Market

In the majority of examples of recent initiatives highlighted in this review, from implementation of new government policies, pilot programs, and multidisciplinary care system integration, ensuring adequate human capital was identified as a key barrier to achieving desired outcomes.

Rural service providers report higher-than-average levels of professional isolation, role confusion, distress, burnout, and earlier exits from the public system (Barker et al., 2023). For example, psychologists in Canada are increasingly moving out of schools, hospitals, and public health offices, towards private and fee-for-service clinics where they have autonomy in managing their workload. This trend has been particularly challenging for rural communities, which often face serious staff shortages and a lack of interprofessional health teams. To attract and retain workers, rural communities should first assess what factors are affecting labour supply and demand in their region. These factors might include housing supply and affordability, availability of childcare, presence of peer support workers and crisis intervention teams, consistency of program funding, capacity for co-located services, and quality of IT support (MHCC, 2012, 2019, 2020; ROMA, 2024).

4.2.2. Development of Rural-designed Models of Care

Despite gaps in systematic and longitudinal rural-specific data monitoring, there is a growing body of evidence to support investment in community-centred, multidisciplinary, and co-located MHA services in rural Canada to reduce care delays, demand on psychologist and emergency services, and hospitalizations (Masse et al., 2023; ROMA, 2024). There have already been efforts made in some communities to better integrate MHA care with the existing healthcare system. Unfortunately, due to a number of resource constraints (e.g., short-term funding, inflexible funding criteria) it is not a widespread practice to consistently include mental health professionals on healthcare teams, nor rural service providers in urban-based professional support networks (MHCC, 2024).

4.2.3. Digital Navigation Support in Rural Communities

Along with labour and service design considerations, the third major theme to emerge from our analysis was a need to support system navigation for rural service providers and clients, particularly in the form of digital technology supports. High-speed Internet coverage in rural areas of Canada has steadily improved albeit at a slower pace than projected by the CRTC. To address the rural digital divide, recommendations from the Canadian private sector include: government subsidies to incentivize Internet service providers (ISPs) to invest in rural infrastructure development; utilization of fixed wireless internet technology; local collaborations to explore alternative solutions like community-owned networks; and policies aimed at promoting competition among ISPs (CanNet, October 2022).

Once a rural area has attained adequate connectivity for accessing digital and virtual MHA services, both service providers and service users may require ongoing support to make optimal use of available resources. Some of the literature found rural service providers were less likely to adopt new digital tools into their practice due to a lack of perceived readiness, misalignment with their local processes, and privacy concerns. They were also often struggling to maintain a reasonable workload given the compounding effects of their expanded scope of practice, administrative tasks, and workplace gaps in digital technology and IT support. The MHCC has made some efforts to address these issues in the creation of an implementation readiness tool for service providers to navigate their E-mental health options, as well as highlighting the benefits of system user navigation sites (e.g., Head to Health) in their new e-mental health strategy (MHCC, 2024).

4.3. Thematic Results of the Review

In the following results, MHA supports and services in rural Canada are highlighted using a tiered approach. Following this overview of the scope of rural supports and services by tier, in the next section we present more detail about recent MHA initiatives in rural Canada, many of which fulfill several tiers of service through multidisciplinary and multisectoral collaboration.

4.4. Tier 1: Health promotion and illness prevention (Whole population)

Supports and services considered in Tier 1 are:

> Broad efforts that draw on natural systems and networks of support for individuals, families, and communities. They provide a foundation for a healthy population, and have broad eligibility criteria, allowing anyone to access them (National Treatment Strategy Working Group (NTSWG), 2008).

Tier 1 supports may include mental health awareness initiatives, neighbourhood associations, and community support groups, catering to both the general population as well as at-risk populations. In the literature, initiatives designed for a certain sub-population most often focused on children and youth, agricultural workers, and Indigenous peoples. Health promotion topics included self-care and wellness (e.g., healthy relationships, addictions, mindfulness, coping with stress, physical activity, food guides, sleep hygiene), parent resources (e.g., recognizing signs of depression and anxiety in children, developing resiliency), staff training (e.g., Mental Health First Aid) and safety online (e.g., digital media literacy, awareness of online harms). These programs have been offered through telehealth and online modalities, as well as in-person programming.

A rurally-focused example of Tier 1 programming includes Mental Health First Aid First Nations (MHFAFN), which offers culturally safe and community-oriented mental health literacy training, empowering individuals to recognize and respond to crises within their communities (Crooks et al., 2018). Programs such as these are tailored to meet the unique needs of rural residents, fostering a sense of community and reducing stigma associated with mental health issues (Braganza et al., 2019; Zitars & Scharf, 2024).

The MHCC has previously framed mental health and addictions stigma as a byproduct of the mainstream Canadian societal values of individualism and self-reliance (MHCC, 2022). There is considerable qualitative data to suggest that stigma is more pronounced in rural communities than urban ones due to rural communities having a more dominant culture of self-reliance, in part stemming from their agrarian and industrial roots as well as long-standing experiences of “doing more with less” (Giles, 2023; Hallstrom, 2023; Pullman & Singleton, 2004). Given that MHA stigma inhibits help-seeking behaviour and sometimes leads to the development of unhealthy coping mechanisms, additional considerations should be made in rural MHA service planning in terms of tailoring public awareness campaigns to align with a community’s background. Some

research in Australia has highlighted how it may even be preferable in rural communities to implement mental health literacy programming that focuses on skill development rather than increasing awareness only (Mandal & Burella, 2021).

Mental health literacy programming is also commonly offered in primary and secondary schools across Canada. A rural-focused Tier 1 MHA support with a growing body of supportive evidence is a school-based initiative called Mental Health Capacity Building (MHCB) in Schools. It provides health promotion, prevention, and early intervention MHA services to children, youth, and their families using a multidisciplinary team approach. This program was initiated in Alberta and has recently been piloted in Saskatchewan (Alberta Health Services, n.d.; SARM, 2023). A recent qualitative evaluation of the MHCB pilot in Saskatchewan found the greatest strengths of the program were the presence of an on-site staff member for direct information and the program's creation of a space for proactive mental health conversations (Hassan et al., 2023). Positive observed outcomes of the program were students engaging in more help-seeking behaviour (e.g., self-referrals) to get support for emotional self-regulation, as well as bridging care between the school setting and external services for at-risk students. Teacher involvement in program delivery was considered an important factor in success as they were able to share program information with students regularly. Identified challenges included reluctance among teachers and students to participate due to perceived mental health stigma or misalignment between program mandates and school curricula. Further quantitative evaluation of the MHCB program in Saskatchewan was underway at the time of this publication (Hassan et al., 2023).

School-based mental health literacy programs have also targeted specific issues, such as binge substance use. One program called Preventure has previously been piloted in rural Nova Scotia for students aged 14-17 years (Conrod et al., 2006). In this program, therapists conducted two sessions with participants to teach cognitive and behavioural coping skills using motivational theory. After taking part in the program, youth participants reported reduced alcohol intake and fewer drinking-related problems. Unfortunately, the vast majority of research on adolescent substance use interventions has been conducted in urban settings (Patton, 2013), possibly limiting scalability to rural settings.

In the grey literature, we identified several other examples of rural-focused mental health literacy initiatives developed at the local and regional levels. However, these initiatives had not undergone evaluation and the information available was only descriptive in nature, giving no indication of uptake, outcomes, facilitators, or barriers to success. These initiatives will be presented in this review's adjacent environmental scan of MHA supports and services available in the study region.

4.5. Tier 2: Screening and initial assessment/intervention (Low needs)

Supports and services considered Tier 2 are screening services, short-term interventions, and referrals, and can be offered in primary, emergency, and public health settings, as well as social service and employment programs (NTSWG, 2008).

4.5.1. Health care and social services

Continuous psychology and psychiatry services are absent in many rural areas of Canada (Barker et al., 2023), and so primary care providers often serve as the frontline of MHA care. In the absence of MHA specialists, family physicians and nurse practitioners can provide assessments, diagnosis, and treatment (Kant et al., 2019; Letto et al., 2018; Poghosyan et al., 2019), but they and their patients stand to benefit from timely access to MHA specialists for case-specific consultations and professional education (MHCC, 2020). In some regions of Canada, rural primary care providers have access to additional certificated education and training (e.g., Provincial Addiction & Mental Health Curricula & Experiential Skills (PACES) in Alberta) to expand their scope of practice in MHA care (AHS, n.d.).

In addition to individual-targeted efforts, programmatic changes have also taken place in primary care services to better serve rural communities, with many recent initiatives taking place in rural Ontario. For example, the Extension for Community Health Care Outcomes (ECHO) model has been implemented in rural Ontario, B.C., Quebec, Newfoundland, as well as parts of the U.S. and internationally (Masse et al., 2023). The ECHO model, first launched in Ontario in 2015, offers education-based, virtual access to expert interdisciplinary teams for primary care providers. The model has shown good uptake, high retention, substantial cost savings, and overall program sustainability.

Specific to mental health, the ECHO model has also shown to increase capacity among rural services providers to support clients with intellectual and developmental disabilities. Ontario has also piloted rural-focused addictions interventions such as the Rural Outpatient Opioid Treatment (ROOT) program, which integrates opioid treatment within primary care settings, offering comprehensive services including group recovery, peer support, and opioid agonist therapy (Buck-McFadyen et al., 2021). Changes such as these to our health care systems highlight how our collective “understanding of the importance of mental health has grown, [as well as the] need to consider mental health in Canada’s care models in the same way we approach physical health” (MHCC, 2024).

This shift in Canada’s care systems to a more holistic understanding of health necessitates collaboration between many different types of health and social professionals, especially in rural areas that face resource constraints. An example of how rural MHA service providers have worked together to mitigate gaps in local supports and services has been through regular in-person interdisciplinary meetings, involving school board representatives, social and victim services, probation officers, child welfare workers, and nearby urban-based providers, to assess case-by-

case situations together and decide if further intervention is necessary, and if so, by whom (Glover & Bell, 2023). One such collaborative effort came about in rural Ontario after provincial police officers realized that a significant portion of their calls were for MHA issues that fall outside of their mandate, but if they receive a call they are required to attend regardless. This region's Situation Table led to a decline in police calls and emergency presentations for MHA issues, and its success has been attributed to in-person meetings, strong leadership, and stakeholders' consistent priority to provide inclusive, adaptive, and timely care (Glover & Bell, 2023).

4.5.2. E-mental health supports and services

Mental health supports and services delivered through a type of technology, whether it be by telephone, videoconferencing, web-based interventions, mobile devices, social media, virtual reality, or gaming, is often called "e-mental health" (Mohr et al., 2017). In the MHCC's 2012 Mental Health Strategy for Canada, e-mental health was identified as a potential support for all six strategic directions (see Table 1 below). Demonstrated benefits of e-mental health include improved service availability (e.g., specialized consultations), increased convenience, higher perceived confidentiality or privacy, increased educational opportunities, and reduced isolation, stigma, waitlists, missed appointments, travel time, costs, and hospitalizations (Lo et al., 2022; Masse et al., 2023; MHCC, 2020). An identified gap in our knowledge of e-mental health care outcomes is a lack of studies of service user experiences and comparative studies between telehealth and face-to-face services (Masse et al., 2023). However, one 2018 meta-analysis focused on cognitive behaviour therapy did find similar patient outcomes between face-to-face and Internet-delivered psychiatric services (Carlbring et al., 2018).

Table 1: Potential Uses for E-Mental Health in Fulfilling the Mental Health Commission of Canada's Strategic Directions (Adapted from MHCC, 2014, p.5)

Strategic Direction	**E-Mental Health Potential**
Promotion and prevention	Promote "healthy thinking," treat early onset disorders
Recovery and rights	Chronic illness management
Access to services	Improve access in time (waiting lists) and geography
Disparities and diversity	Opportunity to personalize health care and tailor support for different communities
First Nations, Inuit, and Metis	Opportunity for remote services – e.g., through robots. Culturally acceptable interventions
Leadership and collaboration	A whole government approach is required to manage how technology is used in mental health care

E-mental health services have become essential in making MHA care accessible in rural Canada. National services include the (SARM, 2023):

- Canada Suicide Prevention Service
- Kids Help Phone
- Mental Health Criss Hotline
- Hope for Wellness Help Line
- Trans Lifeline

These initiatives often have some form of a database for users to search for mental health supports available in their home region. Virtual mental health services have gained momentum, particularly during the COVID-19 pandemic (Canadian Medical Association, 2022), offering flexibility and convenience that in-person services often cannot (Friesen, 2019; Hynie et al., 2022). There have been recent successes with pilot programs offering virtual triage and assessment in rural Ontario and Manitoba. In rural Ontario, the Virtual Triage and Assessment Centre provides care for patients who do not have a family doctor through virtual consultations and paramedic home visits (ROMA, 2024). The Local Health Hub program also provides virtual psychiatric services through rural hospitals (Mandal & Burella, 2021). In rural Manitoba, the Rural Emergent Telepsychiatry and Integrated Virtual Ward Program's pilot projects helped over one thousand clients and prevented 246 medical transports and 138 hospital admissions over two years (Government of Manitoba, 2023).

In addition to benefits to primary and acute care health services, digital technology has also enhanced the capacity of rural residents to access virtual peer supports and mental health literacy programs. Peer support programs have shown to be better received and more effective in rural areas of Australia when they were geared towards empowering participants to support the mental health needs of one another, balancing values of social interconnectedness and self-reliance (e.g., mental health first aid training) (Mandal & Barella, 2021). Less successful interventions were found to be those that focused on mental health awareness and anti-stigma education only. A similar trend of success with public mental health skills development in rural areas has been observed in Ontario through Consumer/Survivor Initiatives (CSIs) ongoing since the early 2000s (Mandal & Barella, 2021). CSIs are provincially funded and offer community MHA peer support and services (Shute & Theodorou, 2024). Funding constraints mean that many sites do not engage in regular data collection to monitor the impacts of their work. Researchers have suggested that participatory action program evaluation for CSIs could "help the sector tell their story and remain a vital part of the community MHA system in Ontario" (Shute & Theodorou, p.51).

Across our collected literature, **the most identified key to success in virtual mental health services was interprofessional and intersectoral collaboration that integrates with existing networks in a rural community, during all phases of design, implementation, and evaluation (Lo et al., 2022; Masse et al., 2023; MHCC, 2020).** However, digital and virtual administrative pathways for coordinating MHA care continue to pose some unique challenges for rural service

providers. For example, a mental health professional from rural Ontario shared an observation about the post-pandemic shift towards a preference for virtual meetings over in-person, but that this had negative consequences for patient care. In face-to-face interdisciplinary meetings, patient cases could be transferred by an approach known as a "warm handover," but in virtual interactions, the referral process has become more formalized and does not include consideration of geography nor limitations in human capital of the referring institution (Glover, 2023). While virtual meetings come with savings in time, travel, and efficiency, they can also pose challenges in terms of interagency negotiation, intraoffice protocols, and legal concerns (DeHart et al., 2022). Some MHA research has also shown that virtual outreach with rural service providers may not result in optimal rates of engagement or uptake, and that the deployment of resource-persons to rural service centres is a preferable method in the implementation of new policy and programs (Cerda et al., 2017; Perreault et al, 2023).

Despite technological advancements and a growing body of evidence to support models of virtual mental health care, the long-standing issue of the rural digital divide persists, with some rural communities continuing to face serious challenges in attaining high-speed Internet (38% of rural households in Canada were without access to high-speed broadband as of January 2025) (CRTC, 2025), sufficient technology infrastructure (e.g., public Wi-Fi), digital literacy support and professional training, and privacy measures in implementing e-mental health interventions (AMINI, 2022; CIHR, 2022; Lo et al., 2022; Masse et al., 2023; Synergy Youth and Community Development Society, 2023). In a December 2024 review of Canada's Broadband Policy Fund for capital projects, the major critiques provided by the CRTC reviewers included insufficient regulation of transport costs, resulting in a wide variability across subsidized projects, as well as a lack of coordination between local, provincial, and federal programs resulting in overbuilds (network duplication) (CRTC, 2024).

Along with issues of digital infrastructure, connectivity, and training for professionals, the design of virtual MHA supports and services also requires rural-specific considerations. As Lo et al. (2022) stated in a science brief on virtual mental health care in Canada:

> While virtual mental health care has the potential to address barriers to access to care for rural and underserved communities, it may also propagate existing inequities in mental health care for under-resourced populations. Many challenges to the delivery of equitable care through virtual mental health remain. Enhancing technological literacy and access for clinicians and clients and delivering culturally competent care that aligns with the needs of the local population and community is a largely unaddressed priority for advancing transparency, trust and equity… There is also important work that must be done at a health systems level to ensure that there is a planful system of virtual care provision, or the risks are discontinuity of care, maldistribution of care, and service providers who are unfamiliar with the community, and cultures, and contexts in which they are providing care (p.1, 6).

Beyond better supporting implementation, there are additional considerations for further developing e-mental health services for rural areas which include: supporting the role of information technology (e.g., electronic health records); remaining sensitive to newly evolving technologies and those that are becoming obsolete; ensuring there are safety protocols for high-risk cases; and the potential effects of health information being widely available on the Internet (e.g., patient empowerment) (Masse et al., 2023; MHCC, 2014).

4.6. Tier 3: Community-based, outreach, social support, and rapid-access services (Moderate needs)

Supports and services considered Tier 3 are active outreach, risk management, and basic assessment and referral services (e.g., outpatient counselling, home-based management, supervised injection sites) (NTSWG, 2008).

4.6.1. Community-based, outreach, and social support programs

Community-based, outreach, and social support programs are at the heart of mental health service delivery in rural Canada. Community-based programs can respond to the needs of specific populations and include rural-focused initiatives such as the ACCESS Open Minds initiative for youth mental health (14 communities across Canada) (Dube et al., 2019), and the National Native Alcohol and Drug Abuse Program (NNADAP) which provides culturally appropriate support for Indigenous communities (Duncan et al., 2020; Government of Canada, 2019; Health Canada and the Public Health Agency of Canada, 2016). The availability of single "doorway" sessions made possible through community-based initiatives such as these has been shown to be the greatest contributor to reduced wait times, even compared to e-mental health pathways (MHCC, 2019).

To further support rural residents' access to MHA care, as early as 2004, some regions in Canada (including Alberta, Manitoba, New Brunswick, Nova Scotia) (Letto et al., 2018) began to "offer travelling care services (e.g., school-based programs, mobile clinics) to specific rural and remote communities, so clients can access help closer to home" and be referred to specialized care (stepped approach) as needed (MHCC, 2020, p.2). The section Stepped Care Delivery Model will explore further details about this approach to MHA service delivery in rural Canada.

Mental health interventions for agricultural workers

Research on the mental health of people in Alberta's agricultural sector has primarily focused on identifying problems and/or assessing needs. An important message to emerge from one study of farmers (N=561) was the importance of including agricultural workers' perspectives in program design and delivery, as their health priorities may differ from the typical priorities of the medical model. For example, although cardiovascular disease is considered by many healthcare professionals to be the top priority for health promotion, in this study participants were most concerned about their respiratory health, back injuries, and mental health (Thurston et al., 2003). When it came to mental health, participants were concerned not only for their own mental health

but also of their immediate family and the potential negative impacts of agricultural work on them (e.g., work-related stress). Both this study and a more recent study of Hutterite farmer mental health in southern Alberta (Adandom et al., 2023), participating farmers' reported symptoms of stress, anxiety, and depression tended to be mild.

4.6.2. Crisis, emergency, and rapid-access services

Interventions for people in rural Canada experiencing MHA crises can include 24/7 telehealth and virtual supports as well as mobile crisis and rapid-access teams with specialized training (e.g., overdose management). Crisis centres and 24/7 crisis phone lines provide immediate support, connecting individuals to resources and care. In Canada, these phone lines include a national suicide crisis helpline, helplines for certain Indigenous people (e.g., residential school survivors), as well as provincial and territorial helplines. In addition to telehealth and virtual support, some rural regions have access to mobile crisis teams that are capable of delivering on-the-spot intervention and timely assistance that can prevent the escalation of mental health emergencies (Braganza et al., 2019; Zitars & Scharf, 2024).

Several pilot programs for enhancing crisis and rapid-access addictions services have been implemented in rural Canada, including supervised consumption services in rural B.C. (Mema et al., 2019), rapid-access addictions services in rural Manitoba (Herron & Young, 2024), co-responder teams (police and mental health professionals) (Zitars & Scharf, 2024) and mobile youth services (Braganza et al., 2019) in rural Ontario, and overdose training in rural Quebec (Perreault et al., 2024). **The researchers conducting these program evaluations identified major quantitative and qualitative data monitoring gaps in terms of rural service delivery and user experiences, hindering comparative discussion and identification of best practices. In discussion of implementation in rural sites, there was a clear focus on qualitative description of challenges, with few stories of success shared.** Challenges included funding constraints, internal communication and scheduling, inflexible modes of delivery, geographic isolation, and a lack of trust and awareness among service users (e.g., stigma, cultural and colonial divides).

4.7. Mental Health and Addictions Interventions in Rural Canada

Accessibility of mental health supports and services has been a long-standing issue in Canada, especially for people who live outside of urban centres (CMHA, 2021). In an effort to improve accessibility, communities across Canada have adopted some combination of providing services through primary and acute health care settings, crisis intervention teams, non-government organization initiatives, telehealth and online supports, and community-based networks. In this section we highlight examples from the literature of recent rural-focused initiatives within each of these service delivery modes.

The purpose of this section is to highlight MHA policy and programs that have been evaluated for their effectiveness in a rural region, show promise for continued implementation, and can serve as a model for other regions looking to improve their MHA supports and services. A jurisdictional scan of rural psychiatric services was conducted in 2018 (Letto et al., 2018) which provides detail about 9 programs across the country (NS, NB, ON (4), MB, AB, BC). The programs and initiatives highlighted below are in addition to those in Letto et al.'s review and may have a central focus on supports and services outside of psychiatry (e.g., community mental health workers).

4.7.1. Stepped Care Delivery Model

The Stepped Care delivery model was developed in the UK and has featured prominently in Canada's e-mental health strategy since 2019 after pilot projects were conducted in Newfoundland and Labrador through a multisectoral partnership between the MHCC, a university, the provincial government, and four regional health authorities (*Stepped Care 2.0*) (MHCC, 2019). These pilot projects involved implementation of "stepped" supports across eight levels, ranging from online self-help in Step 1 to specialist and psychiatric care in Steps 7-8. Interviewed service users reported appreciation for receiving more timely MHA care tailored to their needs. One participant stated, "Before stepped care, it was like waiting to get access to a backhoe when all you need is a shovel" (MHCC, 2019, p. 31). In a six-month user outcome monitoring period, approximately one-quarter of Stepped Care clients showed significant improvement in their well-being and life-functioning. A limitation of this round of monitoring was its short-term nature and a biased sample consisting mostly of female and highly educated clients. No long-term outcome monitoring for Stepped Care programs has yet been published.

Key learnings from the pilots in terms of program implementation were the need for political will among all involved government bodies to change the mental health system, dedicated staff positions, trainers, cross-site coordination, evaluation support, as well as early and frequent engagement with stakeholders (e.g., community members with lived experience, community organizations, specialized expertise such as I.T. and communications) (MHCC, 2019, p.40-41). Rural sites for this project saw a greater level of collaboration between service providers (namely social workers) and clients to develop programming, thought to be due to scarcer resources and

thus a greater need to be innovative. Rural service providers suggested several areas for improvement to the model in the future, including:

- More of a team-building approach to implementation to alleviate confusion and integrate different components of existing programs.
- Communications and graphic design experts should develop coordinated marking and messaging to facilitate more digestible information sharing and help providers and clients make use of new resources.
- Technology development should integrate with existing infrastructure and systems (e.g., infrastructure outfitting, privacy regulation compliance, electronic record systems) and involve outcome monitoring.
- Professional training that is structured so people joining later in program implementation have access to resources to catch themselves up.

Following the initial promising outcomes of Stepped Care delivery in Canada, from 2020 to 2024, the Wellness Together Canada (WTC) portal was developed through Stepped Care Solutions and offered 24/7 virtual MHA services without need for a referral, ID, insurance, assessment, or diagnosis (Stepped Care Solutions, 2024). The portal received 4.3 million unique site visitors and sixty thousand mobile app downloads, conducted 590,820 assessments, had a 30-day retention rate of 43%, and saved an estimated $36 million dollars in healthcare spending (Greenspace Mental Health, 2025; Stepped Care Solutions, 2024). Aside from search engine use, users were directed to the portal through government websites (17%), provider recommendation (17%), social media (15%), employers (8%), and peers (8%). The majority (55%) of users accessed the portal outside of usual business hours (9am to 5pm). As noted in the Background section, the termination of the WTC program drew sharp criticism from MHA advocates as they believed the WTC offered essential service support to provinces and territories.

4.7.2. Integrated Youth Services Network (IYS-Net)

The IYS-Net is a transformative youth mental health care model serving people ages 12 to 25 across Canadawith approximately 160 sites (105 active, 55 in development as of December 2024) (CIHR, 2023, 2024; SARM, 2023). The project provides “locally relevant, effective, youth-focused and integrated services for mental health, substance use within the community… [including] one-stop shop integrated youth hubs” (SARM, 2023, Response section). Services include primary care (counselling, addiction services, sexual health resources), peer support, work and study supports, and a mix of in-person and virtual offerings.

IYS-Net is a part of Canada’s Strategy for Patient-Oriented Research (SPOR) and is mainly supported by a 1:1 partnership between the Canadian Institute for Health Research and the Graham Boeckh Foundation (CIHR, 2023). Given building evidence for the positive impacts of the IYS-Net, from 2023 onwards additional funding has been committed by the Canadian federal government to expand the network in QC, ON, MB, NB, NS, and PEI, as well as a national

Indigenous expansion, and the creation of an IYS Data Platform to support timely and accurate knowledge sharing (CIHR, 2024).

4.7.3. Tablet Injectable Opioid Agonist Therapy (TiOAT)

The Tablet Injectable Opioid Agonist Therapy (TiOAT) program was evaluated to assess its effectiveness in addressing opioid use disorder (OUD) in rural and smaller urban areas of British Columbia. The study focused on understanding the accessibility and impact of TiOAT services in these settings (Bardwell et al., 2023). The study highlighted the positive therapeutic relationships developed within the TiOAT programs, which played a significant role in reducing stigma and providing a supportive environment for participants. Although the study did not directly measure mental health symptom reduction, the social bonds and stigma-free environment were reported to contribute to improved mental health outcomes. However, the study also identified substantial barriers to accessing TiOAT services, including geographic challenges, transportation issues, and the requirement for multiple daily visits to clinics for witnessed ingestions. These barriers were particularly pronounced for participants living in remote areas, likely impacting overall service utilization.

Despite these challenges, high levels of satisfaction were reported among participants, especially regarding their interactions with clinic staff and the supportive atmosphere within the programs. The contrast between the positive environment in TiOAT programs and the stigma experienced in other healthcare settings contributed significantly to this satisfaction. The TiOAT program demonstrated strengths in fostering therapeutic relationships and reducing stigma, which are important factors in mental health outcomes.

4.7.4. Cognitive Behaviour Therapy with Mindfulness (CBTm) and Telepsychology

The Cognitive Behaviour Therapy with Mindfulness (CBTm) program aimed to assess the effectiveness of CBTm classes delivered in rural community settings, both in-person and via telepsychology (Davidson et al., 2022b). The study found significant reductions in psychiatric symptoms, including anxiety and depression, among participants who attended CBTm classes. The most substantial improvements were observed between the first and second classes, demonstrating the program's effectiveness in reducing mental health symptoms in rural populations. Approximately half of the participants engaged in additional mental health services after completing the CBTm classes, suggesting that the program served as an entry point for further care. However, the study also identified a high dropout rate, with about two-thirds of participants not completing all four classes. This dropout rate poses a significant barrier to realizing the program's full potential. Participants generally rated the usefulness of the classes positively, with many expressing interests in attending future sessions. Despite the positive feedback, the high dropout rate raised concerns about participant engagement and retention, as the study was unable to identify significant predictors of dropout.

4.7.5. Rural Mobile Crisis Service for Children and Youth

The Rural Mobile Crisis Service program focused on the effectiveness and impact of mobile crisis interventions for children and youth in rural Ontario (Braganza et al., 2019). The study reported significant reductions in distress levels for both youth and parents or guardians following engagement with the mobile crisis service. This reduction in distress persisted over time, indicating the service's effectiveness in managing acute mental health crises. The study also provided data on the frequency and nature of crisis calls, with a significant proportion related to suicide risk and self-harm. However, it did not offer detailed longitudinal data on whether service utilization, such as hospitalizations, decreased post-intervention. Participants expressed high levels of satisfaction, appreciating the support and understanding provided by crisis workers. Despite this positive feedback, the study noted that calls were more frequently made about female youth, raising questions about the service's accessibility and effectiveness for male youth.

4.7.6. Community Helpers' Mental Health and Suicide Awareness Training Programme for Youth and Young Adults

The Community Helpers' Mental Health and Suicide Awareness Training Programme aimed to support mental health and suicide prevention among youth and young adults in Alberta, Canada (Loitz et al., 2024). This peer-helping program focused on equipping participants with the knowledge and skills necessary to recognize and address mental health issues in their peers. The study focused on improvements in knowledge, self-efficacy, and awareness of mental health issues, rather than directly measuring the reduction of clinical mental health symptoms. Participants showed significant increases in knowledge and self-efficacy immediately after training, which are crucial for early intervention and prevention. Although there was a slight decline over six months, the levels remained higher than pre-training. While the program effectively enhanced participants' ability to recognize and address mental health issues, it did not provide direct evidence of reduced mental health symptoms among participants or those they assist. Regarding service utilization rates, the study highlighted the role of Community Helpers in directing peers to appropriate mental health resources. However, it did not provide detailed data on whether the program led to an increase or decrease in the utilization of formal mental health services. This leaves a gap in understanding how the program might influence long-term engagement with mental health services.

Participants generally reported high levels of satisfaction with this program, valuing the training content, the engaged learning approaches, and the support from coordinators. This suggests that the training was well-received and considered useful. However, some participants indicated a need for better cultural tailoring, particularly for Indigenous communities and LGBTQ2S+ youth. Participants suggested the need for ongoing support to maintain the skills and knowledge gained during the program. The Community Helpers program demonstrated effectiveness in increasing knowledge and self-efficacy related to mental health and suicide prevention, with high satisfaction levels indicating that participants found the training relevant and beneficial. However, the lack of

direct measures of mental health outcomes or service utilization limits the ability to fully assess the program's impact. The slight decline in knowledge and self-efficacy over time also suggests a need for ongoing support and refresher training to sustain the program's benefits.

4.7.7. Occupation-Based Mental Health Program

The Occupation-Based Mental Health Program was developed by the Northern Initiative for Social Action (NISA) in Northern Ontario, Canada (Rebeiro Gruhl et al., 2021). The program was designed to address participants' needs in three key areas: being, belonging, and becoming, aiming to improve overall mental health and well-being. The study found that the Occupation-Based Mental Health Program significantly improved participants' mental health and quality of life. Using the 3B~S Scale, participants reported high agreement that the program met their needs in being, belonging, and becoming, with mean scores indicating overall mental health improvements (4.16 out of 5) and satisfaction (4.38 out of 5). Participants also reported reduced reliance on traditional mental health services, such as hospitals and emergency services, though the study did not assess long-term service utilization. Despite the high satisfaction, participants suggested improvements, including more culturally diverse programs and better support for older participants. However, the study's reliance on self-reported data and lack of a control group limits the ability to draw definitive conclusions about the program's effectiveness. The absence of long-term data on service utilization further restricts understanding of sustained impact.

Summary

The specific MHA strategies and interventions described in this section have shown promise, and have also contributed to knowledge about the specific implementation needs, common barriers, evidence gaps, and equity considerations that influence rural-based MHA programming. While many programs and interventions have demonstrated clear potential to improve service access and outcomes for service users, particularly through integrated, flexible, and community-based models, scaling and sustaining these programs requires better long-term evaluation, system coordination, and attention to rural-specific barriers.

the Prentice Institute
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FCSS
Family & Community Support Services

Barons-Eureka-Warner
Family and Community Support Services
Community Needs Assessment (2024-2026)

Environmental Scan

Mental Health and Addictions

5.0. Environmental Scan of Mental Health and Addictions in Rural Canada, Alberta, and the BEW Region

5.1. State of Mental Health and Addictions in Alberta & the BEW Region

Despite 17.7% of Alberta's population living outside of an urban centre, longstanding gaps in rural MHA policy, programming, and reporting continue to negatively impact the mental health and wellbeing of rural Albertans (Statistics Canada, 2022). The Canadian Mental Health Association (CMHA)'s 2024 State of Mental Health Report did not differentiate urban versus rural results in detail, although it was noted in some cases where rural communities in Alberta are known to have greater challenges (e.g., suicide). In the report, Alberta was found to have some of the highest rates of mental health issues, substance abuse, and suicide in the country (CMHA Edmonton, 2024). Compared to national averages, Alberta has a higher prevalence of mood disorders (17.1% more) and substance use disorders (17.9% more), higher rates of suicide (31.2% higher), opioid toxicity deaths (89.4% higher, second to B.C.), and hospitalizations caused entirely by alcohol (27.1% higher), as well as fewer mental health professionals (22.6% fewer) (CMHA, 2024). In the South Zone, the rate of drug toxicity deaths in 2023 was 68.4 people per 100,000 (AB average 40.0 people) (Alberta Substance Use Surveillance System, 2024). The addition of urban-rural granularity to these results would better support informed decision-making in MHA policy and program design.

The environmental scan results suggest that publicly available Canadian provincial/territorial policy frameworks have been very slow to articulate policies containing specific managerial components and intervention approaches to guide comprehensive governance strategies for harm reduction services. The results also suggest that, despite the wealth of effectiveness Canadian policies governing harm reduction services have been produced in a "morality policy environment," (Wild et al., 2017; Brooks, 2020, p.34) in which policymakers have endorsed generic harm reduction efforts but failed to name specific interventions if they are viewed as politically contentious.

Table 4. Mental Health Indicators Across Canada and Urban/Rural Alberta, 2021

	Proportion (%) of Respondents				
Indicator	**Canada**	**Alberta**			
		Large PCs	**Medium PCs**	**Small PCs**	**Rural**
Perceived mental health, very good or excellent	56.9	56.1	53.6	53.3	59.5
Perceived mental health, fair or poor	13.1	14.2	15.7	15.1	11.9
Perceived life stress, quite a bit or extremely	21.1	22.2	20.4	20.1	20.2
Mood disorder	10.5	11.2	12.9	14.2	9.0
Heavy drinking	-	17.0	20.2	21.9	18.3
Daily smoker	8.8	6.8	10.4	11.4	11.7
Strong sense of belonging to a local community	67.0	64.2	66.5	70.0	72.1
Life satisfaction, satisfied or very satisfied	89.7	89.4	88.7	90.0	90.8

PCs = Population Centres

(Source: Statistics Canada. (2024). *Table 13-10-0973-01 Health characteristics, two-year period estimates, census metropolitan areas and population centres* [Dataset]. https://doi.org/10.25318/1310097301-eng)

5.1.1. Mental Health and Addictions in the BEW Region

In 2023, Alberta Health Services conducted a province-wide Community Health Survey. The survey's results are available through a public dashboard down to the Zone and County level (AHS, 2024). For many of the mental health related survey questions, the BEW region counties (Taber MD, County of Lethbridge, County of Warner) and South Zone had comparable results to provincial averages for most indicators (e.g., overall perceived quality of life, experiences of bullying and assault, school failure, financial crises, work problems such as demotions and pay cuts, work stress, housing insecurity, reported screen time, and smoking habits).

Table 5. BEW Results from the Alberta Health Services Community Health Survey, 2023

Survey Measurement	Notable BEW Region Results
Good Neighbour Relations (Yes)	**BEW region (90%)** South Zone and Province (82%)
Feeling a Part of a Community (Yes)	**County of Lethbridge (90.1%)** Province (82.1%)
Volunteerism (Yes)	**BEW region (53.7-58.5%)** Province (44.2%)
Work Stress (Yes)	**County of Lethbridge (31.7%)** BEW region (23.2%)
Alcohol Use (Yes)	**County of Warner (57.5%)** **M.D. of Taber (58.7%)** Province (76.2%)
Spiritual Health (Satisfied)	**M.D. of Taber (90.9%)** Province (79.2%)

(Source: Alberta Health Services. (2024). Retrieved from: https://www.healthiertogether.ca/prevention-data/alberta-community-health-dashboard/)

5.2. Mental Health and Addictions Supports Available in the BEW Region

5.2.1. Primary and Acute Mental Health Care Services

There are several mental health service institutions and programs (acute, rehabilitation, community, and outpatient) located within the BEW region (Table 6), with most centred in Taber and Raymond. Coaldale and Milk River also offer community and outpatient therapeutic recreation programming. Therapeutic recreation is not a specialized mental health or addiction program. Instead, it facilitates recreation and leisure activities among individuals with chronic conditions and disabilities, leading to improvements in function and behaviour.

Table 6. Primary and acute mental health care services located in the BEW region

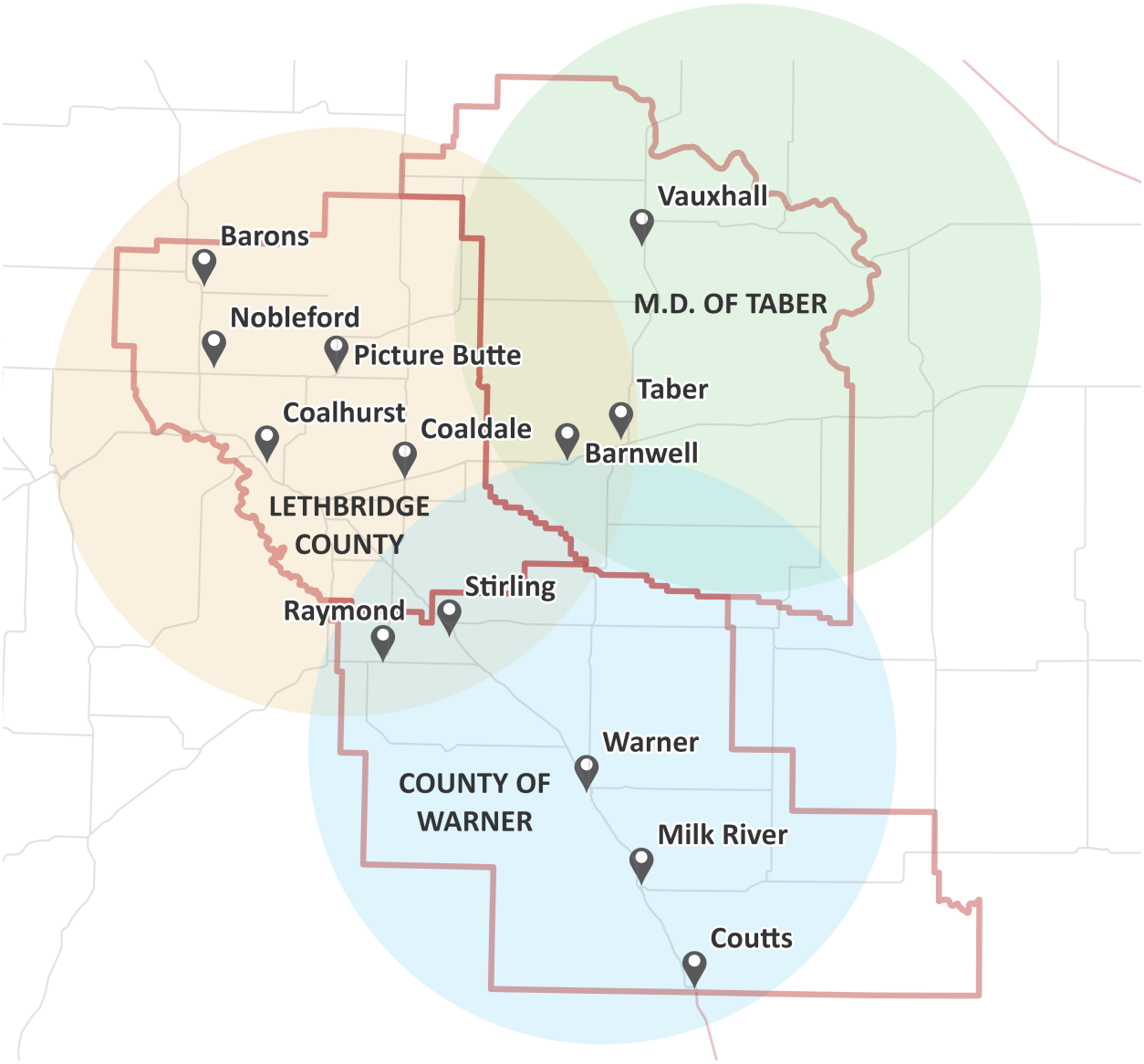
Location	Services Offered
Taber Health Centre	Addiction Services, Community Mental Health Services, Community Addiction Services for Children, Youth, and Families*, and Therapeutic Recreation
Raymond Health Centre	Community Mental Health Services, Seniors Mental Health Rehabilitation Program, and Therapeutic Recreation
Milk River Health Centre	Therapeutic Recreation
Coaldale Health Centre	Therapeutic Recreation

**For child and youth addiction support, Taber Health Centre participates in the Protection of Children Using Drugs program, which is 10-15 days in length and requires families to attend a pre-application information session with an addictions counsellor.*

5.2.2. Family and Community Support Services

Family and Community Support Services (FCSS) provides locally driven, preventative social initiatives with the aim of promoting healthy environments and positive experiences at critical stages in development. FCSS is a joint provincial-municipal funding program designed to establish, administer, and operate social services, with an emphasis on prevention, volunteerism, and local autonomy.

Figure 4. Location of FCSS offices in the Barons-Eureka-Warner region.



FCSS offers mental health programming, including counselling, parenting supports, general interest courses, and programs for sub-populations, including children and youth, seniors, and Indigenous peoples. In the BEW region, specific offerings include intergenerational drop-ins, speakers' series, youth volunteerism projects, sharing circles, caregiver and grief support groups, stay & plays, and learning groups for parents and youth (e.g., how to cope with anxiety). Examples of FCSS offerings elsewhere in the province include youth arts-based leadership programs and 2SLGBTQ+ support groups.

In the BEW region, a point-in-time count of existing programs conducted in November 2025 revealed that, within the month, 65 programs were offered across the region, serving the needs of parenting, children and youth, seniors, counselling, newcomers, and Indigenous peoples. Table 7

provides a count for each type of program offered by FCSS, which consists of either recurring programs and those accessed when needed or necessary, such as counselling, throughout the region.

As seen in Table 6, there is a varying distribution of services for each community based on the program type (i.e., parenting, child and youth, seniors, counselling, newcomers, and Indigenous), most likely determined by need and/or population. Child and youth programs were offered the most throughout the region, with only one community not receiving any child or youth programs within the month. Each community had access to in-person counselling services throughout the month, with consistent services in Coaldale, Coalhurst, Milk River, Nobleford, Picture Butte, Raymond, Taber, and Warner. However, although in-person services were available in Barons, Barnwell, Stirling, and Vauxhall, residents had to call to reserve the service to come to their community (BEW FCSS, n.d.).

The least offered programs across the region were those for seniors, newcomers, and Indigenous peoples, potentially indicating a lack of need in the communities, including a small population accessing specific services, or limited organizational capacity to offer more programs. For services provided in communities, Coaldale, Coalhurst, Raymond, and Taber had the highest presence of programs across the services. The least serviced communities across program categories were Coutts and Warner. The average (mode) of programs offered is four per community; however, differences in delivery may help to infer the level of need, awareness, or people accessing services. Through the analysis of the programs provided by FCSS in November 2025, some programs were cancelled—the reasons for which were not provided on the website—which may indicate once again the level of need/awareness of programs, organizational capacity for running the cancelled programs, and/or other externalities that may not be conducive to the programs (e.g., time of day/week the program would be offered).

Table 7. Available FCSS Programs in the BEW Region, 2025

	BEW-FCSS Programming 2025						
	Parenting	Child & Youth	Seniors	Counselling	Newcomers	Indigenous	**Total**
Barnwell	2	1	0	1	0	0	**4**
Barons	0	2	1	1	0	0	**4**
Coaldale	4	4	0	1	0	0	**9**
Coalhurst	0	4	1	1	1	1	**8**
Coutts	0	0	0	1	0	0	**1**
Milk River	1	1	0	1	0	0	**3**
Nobleford	0	2	1	1	0	0	**4**
Picture Butte	0	1	1	1	2	1	**6**
Raymond	2	5	0	1	0	0	**8**
Stirling	0	2	0	1	1	0	**4**
Taber	1	4	0	1	0	2	**8**
Vauxhall	1	2	0	1	0	0	**4**
Warner	0	1	0	1	0	0	**2**
Total	**11**	**29**	**4**	**13**	**4**	**4**	**65**

(Source: BEW FCSS. (n.d.). *Programs and Events.* https://fcss.ca/events/)

Challenges to FCSS Delivery in Rural Municipalities

Provincial population growth and complexification, in combination with a rising cost of living and public sector reform over decades, has placed a great amount of strain on supports and services across Alberta. In many communities, especially in rural areas, community-based organizations and programs like those offered by FCSS have become the catch-all point of entry for community members who seek formal support (Bellefontaine, 2023). In a 2023 survey of rural FCSS directors, 95% reported increased pressure since 2018 to provide services beyond prevention, and 79% said they felt that their FCSS programs were being forced to take on responsibilities that were meant to be the mandate of other provincial ministries or agencies (Banack et al., 2023). They reported increased demand for help with income support, mental health and addictions, food, shelter, domestic abuse, crime, and assistance with online or phone applications.

Despite the widespread demographic and socioeconomic trends identified in this environmental scan, provincial funding allocated to FCSS has plateaued since 2023 and has been consistently less-than-requested by the FCSSAA (Table 8). To maintain existing levels of FCSS services, almost half of rural FCSS organizations have required their municipal governments to increase their funding contribution from 20% to over 35% of their annual budget, with some municipalities contributing nearly 75%. FCSS program funds are meant to be comprised of an 80/20 split between provincial and municipal government. (Banack et al., 2023; Bolly, 2023). In 2024, the provincial government announced a 10% funding increase to an FCSS major partner program, Family Resource Networks, but service providers continued to voice concern about underfunding, long waitlists, and delayed care (Cummings, 2024; O'Nyons, 2024). The FCSS Association of Alberta (FCSSAA) President has called for a provincial funding allocation of $162 million in 2026 to be able to meet the preventive social service needs of Albertans (Cross Border Network, 2026; Lakeland Connect, 2026).

Table 8. Alberta Provincial Budget for FCSS (2015 to 2027)

Time period:	**2009-2014**	**2015-2022**	**2023-2027**
Provincial funding allocation per year:	$76M	$100M	$105M
FCSSAA requested funding allocation:	$100M	$130M	$162M

(Sources: Cross Border Network (2026). FCSSAA President Talks Budget 2026. Accessed at: https://www.youtube.com/watch?v=8G2aod8w9i4; Alberta Municipalities (2024). FCSS Funding Increase. https://www.abmunis.ca/advocacy-resources/resolutions-library/family-community-support-services-fcss-funding-increase; RMA (2014). FCSS Funding. https://rmalberta.com/resolutions/16-14f-fcss-funding/).

5.2.3. Lethbridge-based Services

In Lethbridge, the Family Centre Society of Southern Alberta offers self-help packages, parent and caregiver supports, a family resource library, drop-in programs, a community kitchen, Blackfoot family supports, referrals, and subsidized counselling. The Family Centre in Edmonton offers additional programming not listed at the Lethbridge location including partnerships with schools, the police, the city, free counselling, specialized resources for 2SLGBTQ+ youth, youth connector staff, in-home family support, as well as training for organizations and employees. Several Lethbridge institutions offer specialized addictions services (Table 9).

Table 9. Lethbridge-based mental health and addictions services

Location	**Services**
Melcore Centre	Community Addiction Services for Children, Youth, And Families
Southern Alcare Manor	Addiction Services For Adults (Long-Term Residential and Transitional)
Lethbridge Recovery Centre, Chinook Regional Hospital	Medically Supported Detoxification
Lethbridge Youth Treatment Centre	Addictions Counsellors, Therapists (Alberta Health Services)
Lethbridge Shelter and Resource Centre	Supervised Consumption Service (Alberta Health Services)

5.2.4. Telephone and Online Supports

There are many different mental health and mental health-related telephone and online supports available to BEW residents.

24/7 Helplines

There are several 24/7 mental health, addictions, violence and suicide helplines for the general population of Alberta, as well as specialized helplines for Indigenous peoples and children:

- Addiction Helpline - 1-866-332-2322
- Mental Health Helpline - 1-877-303-2642
- 811 Health Link - Health Advice 24/7
- 211 Alberta - Community Services
- Indigenous Support Line – 1-844-944-4744
- Crisis Text Line - Text CONNECT to 741741
- Family Violence – Find Supports – 310-1818 (call/text, online chat)
- Income Supports – 1-866-644-5135
- Indigenous Support Line – 1-844-944-4744
- Kids Help Phone – 1-800-668-6868 or text CONNECT to 686868
- MyHealth.Alberta.ca: List of Important Numbers
- Suicide Crisis Helpline – 988
- Talk Suicide Canada call – 1-833-456-4566, text – 45645

These helplines tend to be staffed by a multidisciplinary team comprised of nurses, psychiatric nurses, social workers, occupational therapists, and/or psychologists. By accessing a helpline, service users can receive crisis support, screening and assessments, general information about a topic and service options near them, and education on strategies to better support wellbeing.

Online Resource Libraries

Alberta Health Services offers two online resource libraries: Help in Tough Times and InformAlberta (Alberta Health Services, n.d.). Help in Tough Times contains resource information for mental health, addictions, employment, housing, and issues of diversity and inclusion.

InformAlberta is a provincial on-line directory of publicly funded and/or not-for-profit community, health, social, and government organizations and services. The directory is maintained by partners from across Alberta (health zones and community information & referral services). In 2018, a petition regarding InformAlberta reached 1400 signatures (Change.org, 2018). The petition was for InformAlberta leadership to update their polices to ensure directory listings included clinics providing access to contraception, abortion, comprehensive sexual health education, and gender-inclusive care. The leader of the petition argued that InformAlberta search results predominantly referred clients to agencies opposed to contraception, abortion, and same-sex relationships.

Online Mental Health Support for the Agriculture Sector

To provide targeted online mental health support for agricultural workers, the Do More Agricultural Foundation and AgSafeBC offer educational webinars, mental health literacy, and peer-to-peer support programs (Table 10). Table 11 outlines provincial resources for adults who experience addiction.

There are several examples of rural-focused mental health literacy programs developed at the local and regional levels in Canada and the US. For example, the US Department of Health Services created a Mental Health in Rural Communities Toolkit, with information to support organizations in implementing MHA programs (e.g., farmer mental health, suicide prevention, help for substance use disorders) (RHIH, 2024). Some rural-focused research centres in Canada, including the Centre for Critical Studies on Rural Mental Health in Manitoba, hold annual conferences which may serve as a foundational step towards the creation of such a toolkit.

Table 10. Online mental health support for agricultural workers in the BEW region

Initiative	Description
AgTalk (DMAF)	Peer-to-peer support program (digital) designed for individuals (aged 16 years and older) working in Canadian agriculture. The platform connects individuals within the agricultural community to each other as well as to mental health communities, facilitating an anonymous digital platform for peer support. AgTalk is entirely anonymous and is clinically moderated 24/7 to ensure a secure environment.
In the Know (DMAF)	A farm-focused mental health program with in-person events as well as an online series which has included targeted sessions for Chicken Farmers of Canada
Talk Ask Listen (DMAF)	The 4-hour workshop was designed and is facilitated by both mental health professionals and those with lived agricultural experience. Online series has included targeted sessions for egg, potato, and cattle farmers. The workshop is also offered in-person across several Canadian locations, including Coaldale in November, 2025.
Field of Mind: Supporting Men's Mental Well-Being (DMAF)	1-hour meeting to hear real-life stories from men who have faced mental health challenges in agriculture, practical tips and tools that have aided them in their journey, and an opportunity to build connections, share, and support fellow participants.
Connection Through Change and Loss (DMAF)	Seasons of Change: Cultivating Connection Through Change and Loss, a 4-part guided online series with a grief specialist to create a space for connection, reflection, and learning to help navigate the grief that comes with life's transitions.
Mental Wellness in Agriculture	Webinar videos (on YouTube) oriented towards health and wellbeing contextualized within the agricultural sector. The webinars discuss

Webinars (AgSafeBC)	everything from healthy habits, fatigue, chronic stress trauma, farming challenges, and stress among many others.

Provincial Online Support for Addictions (For Adults)

Table 11. Provincial Online Support for Adults Experiencing Addictions

Initiative	Description	Link
Self-Management and Recovery Training (SMART) Program	Handbooks, app, virtual meetings to build motivation, coping skills, and self-management. Offers training to be a meeting facilitator	https://smartrecovery-canada.ca/
Virtual Rapid Access Addiction Medicine (VRAAM)	The Rapid Access Addiction Medicine (RAAM) program provides a combination of medical and psychosocial treatment and is based in Calgary with virtual offerings Alberta wide (VRAAM). Access to the virtual program still requires a referral from a healthcare provider.	
Alberta's Virtual Opioid Dependency Program	Digital Overdose Response System (DORS) app allows Albertan's using opioids or other substances to summon emergency response to their location if they become unconscious and provides information on national and provincial addiction recovery supports and services. Also offers telehealth for withdrawal care, transitioning from acute care to corrections, and for those who are in underserved communities. Same day medication starts and gap coverage for suboxone/methadone if service user has no health insurance.	https://www.dorsapp.ca/
Parents Empowering Parents (PEP) Society	Edmonton-based family support programming for families dealing with the effects of substance abuse in youth and adult children, with weekly province-wide virtual group meetings available.	

5.2.5. Mental Health Literacy and Educational Supports

Alberta Mentoring Partnership

Established in 2006, the Alberta Mentoring Partnership is a network of 250 community agencies, government ministries, school authorities, faith organizations, service clubs, and youth groups aiming to develop mentoring resources, toolkits, training materials, as well as engage in research on mentorship programming. Strategic and operational plans for 2023-2026 make no explicit mention of rural considerations, although BEW communities are involved (e.g., Coaldale Prairie Winds Secondary, Vauxhall Schools, and Southern Region 4-H).

Heartland Training & Support Hub (Farm Safety Centre)

The Farm Safety Centre is a charitable organization that has been delivering farm safety programs to rural Albertans since 1991 and is operated through the Raymond & District Future Society. In 2023 the FSC became the Heartland Training & Support Hub.

One program from the Hub with a mental health component was the Sustainable Farm Families program, which ran from 2014 to 2020. This program involved workshops delivered in the fall and winter months when farmers were best able to set time aside to participate. Most workshop goals were focused on either First Aid training/AED acquirement or child safety (e.g., fencing dugouts, building playgrounds to encourage play away from work areas), and some contained a mental health component. Workshop attendee feedback was included in a final 2020 report; positively-reviewed aspects of the program included:

- Registered Nurse facilitators
- Participants appreciated receiving a full health assessment
- Resource Kit
- Goal-setting, including colony-wide goal for Hutterite colonies, and sharing of success stories at successive meetings/workshops
- Involvement of children and youth

Training for General Population Mental Health First Aid and Suicide Prevention

There are several mental health first aid training opportunities available to residents of Alberta (Table 12), with a range of course types, course lengths, and costs.

Table 12. Mental health first aid training opportunities in Alberta

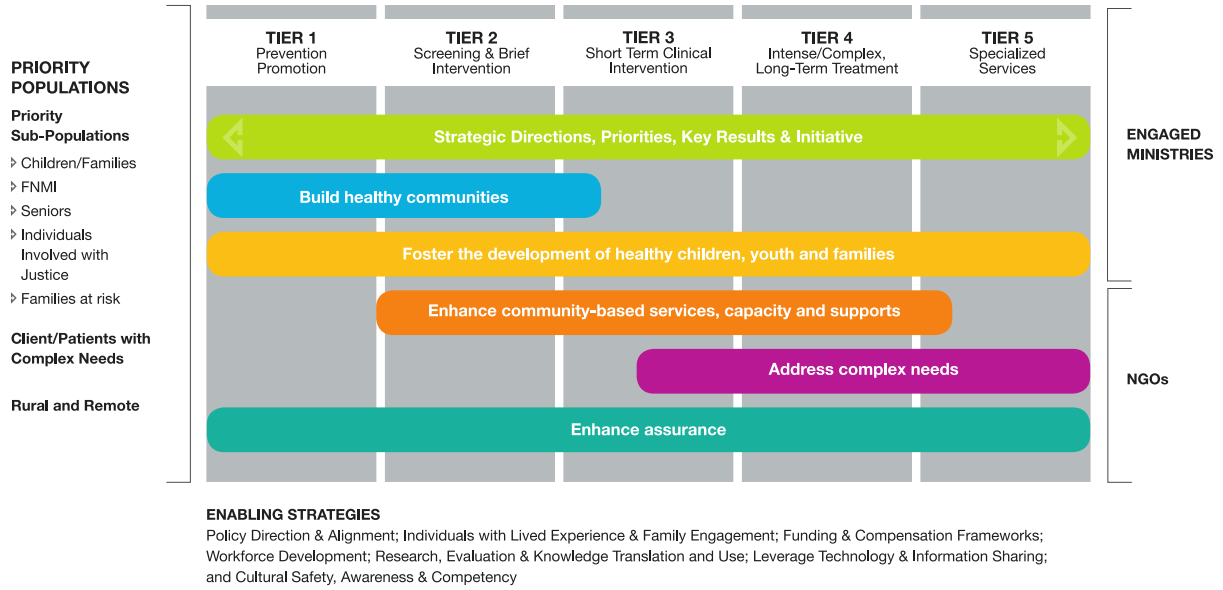
Program (Host Organization)	Description
Mental Health First Aid (Mental Health Commission of Canada)	The MHCC offers three course types: (1) Certification; (2) Essentials; and (3) Community-Based, to meet the needs of different learners. Link: https://openingminds.org/
Psychological First Aid Courses (Canadian Red Cross)	Online and in-person course offerings to help people anticipate stress, recognize distress, and respond early. Link: https://www.redcross.ca/
Start Training (Calgary Centre for Suicide Prevention)	Online skills-based suicide prevention training program (1-2 hours) for anyone 14 years and older Link: https://www.suicideinfo.ca/workshop/start/

5.2.6. Provincial Mental Health and Addictions Strategies (2011 to Present)

Alberta's Addiction and Mental Health Strategy (2011)

In 2011, the Government of Alberta released an "Addiction and Mental Health Strategy." This document explicitly mentions people living in rural and remote communities as a "high priority sub-population" (p. 14) (Figure 5). The word "rural" appears 30 times in this strategy and is often used in referring to a certain rural sub-population (e.g., rural FNMI persons, rural children and youth, rural seniors, and rural immigrants). The strategy included three major priorities in enhancing community-based supports for mental health and addictions, and one of those three priorities was Rural Capacity and Access (p.24), which included goal initiatives such as wraparound service development, accessible follow-up after specialized care, telehealth expansion, mobile outreach teams, and transportation policies. Specific enabling factors in achieving these goals were also identified, including better inclusion of rural service providers in communities of practice, and use of communications technology to access specialized services.

Figure 5. The Government of Alberta's Addiction and Mental Health Strategy (2011)



(Source: Government of Alberta, 2011)

The 2011 Addiction and Mental Health Strategy's focus on rural populations was not extended into the government's newest mental health and addictions framework, "Toward an Alberta Model of Wellness: A Framework for Transformative Change," put forth by the Alberta Mental Health and Addictions Advisory Council in 2022 (see below).

Alberta Mental Health and Addictions Advisory Council (2019-Present)

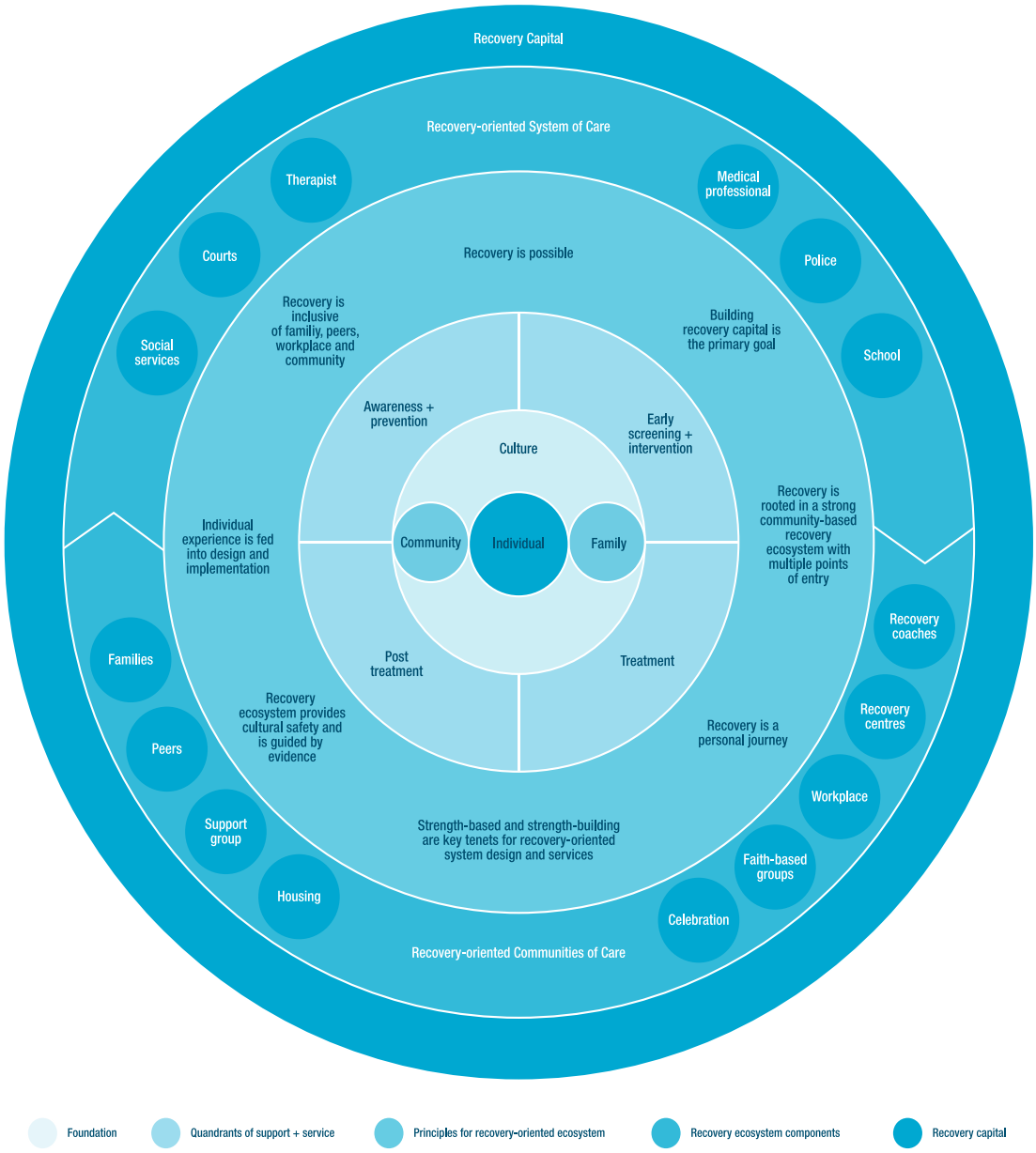
In 2019, the Government of Alberta established the Alberta Mental Health and Addictions Advisory Council, with the purpose of "embarking on a transformative mission to change the way the province approaches mental health and addiction care" (Government of Alberta, 2022). The primary issues identified by the Council in Alberta's existing MHA care were:

- Chronic underfunding of community-based supports,
- The ongoing impacts of the covid-19 pandemic (e.g., financial strain, isolation, opioid addictions).
- User difficulties in navigating the healthcare system.

Following from their assessment of the state of Alberta's MHA care landscape, the Council recommended a shift from a focus on acute mental health care towards long-term management, where mental illness and addictions may require the same level of consideration as other chronic illnesses (e.g. prevention-focused programming, supported referrals, personalized treatment, co-decision making with clients, multi-sector care, reducing stigma). In 2022, the Council published a report outlining the province's new recovery-oriented model of mental health care: Toward an Albertan Model of Wellness: A Framework for Transformative Change. In such a recovery-oriented approach, quality of life is a guiding value, and success relies on the support and participation of schools, workplaces, police/the justice system, faith-based organizations, and families and neighbours to enable individuals challenged by mental illness and addictions to be "proactively involved throughout their journey, as opposed to reactively as is now often the case" (AMHAAC, 2022, p.16).

The new framework as a visual can be seen in Figure 6. The innermost circles represent an individual's Foundation (family, community, culture), the Quadrants represent types of supports and services generally, the next circle contains the framework's major Principles, the System of Care circle outlines the Components within the system (e.g., social services, therapists, peers), and the outermost circle represents the necessary Capital to sustain recovery objectives.

Figure 6. The Alberta Model of Wellness framework (2022)



(Source: Government of Alberta, 2022)

Within the Alberta Model of Wellness (2022) report, three major actions were recommended:

1. Establish an Alberta Recovery Council to create a shared vision.
2. Ensure foundational supports for MHA care are in place (requiring clear direction from the provincial government, centralized coordination, and use of digital technology).
3. Foster innovation through a social investment model with multi-sectoral funding (focusing on risk-based and data-driven interventions with prioritization of scalability, and collaborative and harmonized processes (e.g., curricula design, outcomes measurement)).

Within the key focus areas of the framework (see here for full details) some notable prevention-oriented initiatives include:

- Development of the Digital Overdose Response System mobile app.
- Offer training to police to be able to connect individuals to recovery-oriented services.
- Expanded affordable counselling options through a partnership with Counselling Alberta, where clients can pay what they can afford.
- Increased funding for 211 Alberta to enhance navigation services for rural and underserved communities.
- Increased support for school-based youth mental health programs (e.g., CASA Mental Health Classroom Program and Integrated School Support Program).
- Expanded supports at Kickstand Centres.

Aside from the initiative to enhance 211 Alberta services for rural populations, the word “rural” is not mentioned in the framework itself, a stark difference from the previous provincial MHA strategy, and despite there being well-known unique challenges in rural communities to delivering MHA care across a full spectrum of supports and services.

5.2.7. Federal Mental Health and Addictions Strategies

MHCC: Collaborative Healthcare Exchange, Evaluation, and Research (CHEER)

The Mental Health Commission of Canada conducts program evaluations to improve MHA services across Canada. In 2007, a review of the MHCC recommended the commission to develop more specific goals and objectives. To fulfill this mandate, the MHCC published a new framework: The Collaborative Healthcare Exchange, Evaluation, and Research (CHEER) outlines three key foci, of which rural and remote communities is one. To address human resource shortages in rural and remote areas, CHEER highlights the critical importance of sharing resources through interdisciplinary training and intersectoral relationships (e.g., mental health professionals, peer support workers, healthcare providers, nurses, police and corrections officers). Aside from CHEER, rural and remote community strategies are otherwise mentioned in the MHCC framework only when speaking of First Nations, Metis, and Inuit populations.

Rural Mental Health Project

The Canadian Mental Health Association (CMHA) manages the Rural Mental Health Project in partnership with the Centre for Suicide Prevention. This project focuses on building mentally healthy communities through community-driven approaches, free training in facilitation skills, and asset-based development. Community members can apply to the project to become an Animator, a role that involves compensated training and ability to apply for grants for community-based mental health projects. In the BEW region, there are two community Animators included in the map of Alberta; they are based in Milk River and Taber. Although no BEW-based initiatives were described on the project's website, some examples from nearby communities were found:

- Claresholm: Community Drumming Circles for people of all ages and backgrounds.
- High River: Mental health educational programs for Hispanic and immigrant families.
- Brooks: Local website for mental wellness information.

the Prentice Institute
for Global Population and Economy

FCSS
Family & Community Support Services

Barons-Eureka-Warner
Family and Community Support Services
Community Needs Assessment (2024-2026)

Synthesis and Discussion

Mental Health and Addictions

6.0. Synthesis and Discussion

Mental health is a crucial component of overall well-being. Despite accessibility being one of the pillars of the Canada Health Act, accessing mental health and addictions (MHA) supports and services remains a significant challenge for many Canadians, particularly those residing in rural communities (Beks et al., 2018; Canadian Institute for Health Information, 2023; Friesen, 2019; Masse et al., 2023; Mental Health Commission of Canada, 2021). The vast geography and low population density of rural Canada present unique challenges that affect the delivery of MHA programs and services, as well as professional labour shortages and dynamics across social and economic determinants of health (Asanin & Wilson, 2008; Caxaj, 2016). Although the challenges in rural MHA care have been identified in many studies, there is an ongoing need to share knowledge about MHA interventions in rural contexts, especially the factors that impact their availability, accessibility, and effectiveness (Kavanagh et al., 2023).

Existing research on MHA care in rural Canada has considered integrated healthcare models, digital and virtual tools, and community-based, collaborative approaches to delivering MHA supports and services (Caxaj, 2016; Letto et al., 2018; Masse et al., 2023). This scoping review was conducted to present an analysis of the body of knowledge around MHA supports and services in rural Canada. We aimed to address the following questions: (a) What MHA supports and services are available in rural Canada? (b) What are the facilitators and barriers to their delivery? and (c) What supporting evidence is there to demonstrate positive outcomes from a given support or service?

This review highlights the emerging innovations and persistent challenges (infrastructural, labour, geographic, societal) in providing mental health and addictions supports and services to rural areas of Canada. Across the country, interventions including community-centred collaborative programs, primary health care system adaptations, telehealth, and specialized services for Indigenous and other special populations have shown promise in bridging equity gaps in rural MHA care. The most discussed facilitators and barriers to rural MHA service and support expansion in our collected literature included the need to address gaps in the rural labour market, ensure MHA policy and programs are responsive to local context, and support system navigation for both rural service providers and rural clients.

6.1. The rural labour market

Our review results highlight a major theme of persistent challenges in rural MHA service provision. In the majority of examples of recent initiatives highlighted in this review, from implementation of new government policies, pilot programs, and multidisciplinary care system integration, ensuring adequate human capital was identified as a key barrier to achieving desired outcomes. Rural service providers report higher-than-average levels of professional isolation, role confusion, distress, burnout, and earlier exits from the public system (Barker et al., 2023). For example, psychologists in Canada are increasingly moving out of schools, hospitals, and public health

offices, towards private and fee-for-service clinics where they have autonomy in managing their workload. This trend has been particularly challenging for rural communities, which often face serious staff shortages and a lack of interprofessional health teams.

To attract and retain workers, rural communities should first assess what factors are affecting labour supply and demand in their region. These factors might include housing supply and affordability, availability of childcare, presence of peer support workers and crisis intervention teams, consistency of program funding, capacity for co-located services, and quality of IT support (MHCC, 2012, 2019, 2020; ROMA, 2024). Outside of the immediate local context, labour supply can also be supported through rural-focused higher education initiatives, ensuring an adequate number of postsecondary spaces for primary care programs, building rural rotations into professional training, creating interdisciplinary core competencies, training guidelines, and teams, as well as expanding roles for nurses and nurse practitioners (MHCC, 2012; Paquet et al., 2022; ROMA, 2024). Rural service providers tend to have a long-standing rural background, a preference for variety in professional roles, and an appreciation for outdoor recreation and community factors such as friendliness and slow pace. These trends stress the importance of rural-focused education initiatives (e.g., postsecondary outreach to rural secondary schools), as well as ensuring mental health and educational supports are in place for students from rural communities (Herron & Young, 2024).

In addition to bolstering the health workforce, there is also a need to address shortages of social workers, counsellors, and peer support workers in rural areas (Barker et al., 2023). These jobs are of particular importance given long waitlists for psychologist services; people in these positions can provide services to alleviate some intervention burden for health professionals. However, as noted in this review's Background section, parts of rural Canada are experiencing disproportionate impacts of social service funding stagnation and cuts. Continued advocacy to governments and funding bodies about the importance of investment in lower tiers (1-3) of health and social services as it will "pay dividends over time by reducing the number of people eventually requiring services in the upper tiers" (NTSWG, 2008, p. 20) is crucial, particularly for rural communities where these investments can have relatively larger returns compared to urban communities, considering transportation costs across multiple involved sectors.

Framing the benefits of upstream service investment as financial in addition to social aligns with current trends in government action, both within the Canadian context and globally, to use "public financial power to backstop private investment in areas deemed state priorities, referred to as the 'de-risking' state" (Cohen et al., 2024, p.259). For example, in 2018 the Canadian federal government established the Social Finance Fund (SFF) to address reluctance among the private sector to invest in social services. The SFF contains some targeted funds to address equity concerns (e.g., the Indigenous Growth Fund). However, de-risking may cause tension within sectors when profits are prioritized over upholding consensus values. Situated within the larger context of contemporary neoliberalism and for-profit lobbying in Canada, de-risking actions also threaten the vitality of the non-profit sector (Richmond & Shields, 2024). To sustain the non-profit sector in

rural communities of Canada, it will be crucial for local, regional, and provincial stakeholder groups to engage in advocacy and knowledge mobilization to bring more public attention to issues of antiquated funding models, human resource crises, and an over-reliance on volunteerism.

6.2. Rurally-designed models of care

Despite gaps in systematic and longitudinal rural-specific data monitoring, there is a growing body of evidence to support investment in community-centred, multidisciplinary, and co-located MHA services in rural Canada to reduce care delays, demand on psychologist and emergency services, and hospitalizations (Masse et al., 2023; ROMA, 2024). There have already been efforts made in some communities to better integrate MHA care with the existing healthcare system. Unfortunately, due to a number of resource constraints (e.g., short-term funding, inflexible funding criteria) it is not a widespread practice to consistently include mental health professionals on healthcare teams, nor rural service providers in urban-based professional support networks (MHCC, 2024).

Arguably the key barrier to improving rural MHA services, identified both in some recent literature and highlighted within this scoping review, has been a lack of consistent rural-specific data collection when it comes to MHA illness prevalence, program evaluations, and outcomes monitoring. The word “rural” is absent from key documents and initiatives including the Canadian Institute for Health Research’s 2022 survey about MHA service navigation, the Canadian Institute for Health Information’s new MHA indicator for children and youth (CIHI, 2024), and the MHCC’s new e-mental health strategy (MHCC, 2024). When geographic location is considered in MHA research, rural and remote data are often reported and discussed together as one result, suggesting an underlying assumption that no significant differences exist in MHA supports and services across the range of non-urban regions. There is an apparent need for more rural-focused data and knowledge mobilization to better inform MHA interventions that are flexible to rural realities, and ultimately prevent rural “silencing” (Hammond, 2023, p. 10) in public health policy. However, it is important to remain critical about overreliance on ‘hard’ statistically driven approaches… they often reinforce the status quo and play to neoliberal ‘measurement for success’ paradigms… qualitative-based assessments and data collections that tap into the everyday lived experiences of vulnerable populations, struggling communities, and nonprofits’ activities remain essential (Richmond & Shields, 2024, *The Non-Profit Sector Data Deficit).*

Inclusion of a diverse set of local perspectives when planning and designing MHA interventions at the local, regional, and provincial/territorial levels has been identified by rural service providers as a key to success (e.g., Glover, 2023). Planning ideally includes rural frontline worker perspectives from paramedics, nurses, nurse practitioners, physicians, and psychiatrists, especially given that the MHCC’s Stepped Care program evaluation concluded there were missed opportunities for improvement due to inadequate consultation with service providers (MHCC, 2019). The MHCC has also previously recognized the value in engaging a wider range of stakeholders (e.g., teachers, police, corrections workers, homecare providers) in rural areas to promote resource sharing and strengthen advocacy efforts (MHCC, 2012). Local and regional

consultations with a diverse group of people is key to creating tailored rather than one-size-fits-all solutions to inequities experienced by Canada's heterogeneous rural communities (Dugani & Hubach, 2023).

6.3. Digital navigation support in rural communities

MHA system navigation arose as a challenge for both rural service providers and clients, with digital technology presented as both a contributor and solution to navigation issues. While some efforts have been made to expand digital and virtual MHA supports for rural clients (e.g., additional funding to 211 Alberta), there remains serious issues with broadband access and digital literacy in many rural communities.

High-speed internet coverage in rural areas of Canada has steadily improved albeit at a slower pace than projected by the CRTC. From 2016 to 2024, high-speed Internet availability for rural households increased from 53% to 78%, meaning over 1 in 5 rural households in Canada do not have access to high-speed Internet (50 Mbps download/10 Mbps upload) (CRTC, 2024). Along with coverage, price of Internet services should also be considered in improving equity for rural residents' access to virtual MHA care. In many Canadian provinces, rural customers pay approximately 10% more for high-speed Internet services. It may be worthwhile to investigate the reasons why urban-rural average pricing is nearly the same in Saskatchewan, Quebec, and New Brunswick (CRTC, 2024). To address the rural digital divide, recommendations from the Canadian private sector have included government subsidies to incentivize Internet service providers (ISPs) to invest in rural infrastructure development; utilization of fixed wireless internet technology; local collaborations to explore alternative solutions like community-owned networks; and policies aimed at promoting competition among ISPs (CanNet, October 2022).

Once a rural area has attained adequate connectivity for accessing digital and virtual MHA services, both service providers and service users may require ongoing support to make optimal use of available resources. Some of our collected literature found rural service providers were less likely to adopt new digital tools into their practice due to a lack of perceived readiness, misalignment with their local processes, and privacy concerns. They were also often struggling to maintain a reasonable workload given the compounding effects of their expanded scope of practice, administrative tasks, and workplace gaps in digital technology and IT support. The MHCC has made some efforts to address these issues in the creation of an implementation readiness tool for service providers to navigate their E-mental health options, as well as highlighting the benefits of system user navigation sites (e.g., Head to Health) in their new e-mental health strategy (MHCC, 2024).

7.0. Conclusion

Under-resourcing rural MHA care has contributed to a feeling among many rural communities that they are not a priority for their government (MHCC, 2022). This scoping review's results highlight the importance of intersectoral collaboration within and consultation of rural communities in the design, implementation, and evaluation of MHA supports and services that are flexible to local dynamics and intersecting challenges. Continued efforts to incentivize rural labour, address the digital divide (e.g., adequate broadband speeds, digital literacy training), increase MHA awareness and literacy through relationship-building and advocacy, and monitor outcomes of promising and innovative interventions in rural areas will serve to increase demand, adoption, and uptake of MHA supports and services.

6. **Mental health literacy programs are an important part of supporting mental health in rural communities.**

   BEW Assets:

   - **FCSS' promotion of mental health awareness and information sharing** (e.g., healthy relationship workshops).
   - **Heartland Training & Support Hub (Farm Safety Centre):** A charitable organization that has been delivering farm safety programs to rural Albertans since 1991 and is operated through the Raymond & District Future Society.

   Potential areas for further intervention and assessment:

   - **Mental health and suicide awareness training for community members.**[3] Mental health literacy programs in rural communities have been found to be more effective when there is a focus on skill development (e.g., how to provide neighbour assistance, self-reliance tools). Alberta Health Services offers the *Community Helpers Program*, which provides information and assists community members with developing their competencies to be peer supports for those within their community experiencing mental health challenges.

7. **Multisectoral service coordination can be beneficial for building capacity in rural areas to address mental health and addictions challenges.**

   BEW Assets:

   - The region has several emergency, health, social service, and community organizational partnerships to address social challenges (e.g., **Horizon Victim Services, Safe Haven Outreach Program**) that may serve as a foundation for expanding supports for mental health and addictions.

   Potential areas for further intervention and assessment:

   - **Intersectoral meetings led by mental health counsellors to discuss case-by-case situations—known as situation tables**, inclusive of representatives from school boards, social services, police and the justice system. Meetings and collaboration were linked to a drop in police calls and emergency presentations for MHA issues in rural Ontario.[4]

8. **Co-located services can involve both physical and virtual nesting of services to address an issue, ensuring people have access to multiple services that assist with their needs.**

   BEW Assets:

   - **Health centres** in the region (i.e., Taber Health Centre, Raymond Health Centre, Milk River Health Centre, and Coaldale Health Centre) offer broad healthcare services for both physical health and acute mental health issues.
   - **Physical FCSS locations** in the region provide a range of services, including one-on-one counselling, groups for child development, seniors' activities, and immigration services.

   Potential areas for further intervention and assessment:

   - **Creating a service hub: Co-locating services can look like in-person and virtual MHA support, one-to-one and peer-based counselling, workshops, and employment supports,** all of which are programs run by the *Integrated Youth Services Network (IYS-Net) – Kickstand* (for people ages 12 to 25).[5] The IYS-Net utilizes a co-located model to address mental health and other needs of youth, with 160 sites across Canada, soon to be 7 in Alberta, including Bonnyville, Drayton Valley, Strathmore, and Medicine Hat.

9. **Adapting healthcare systems entails promoting alternative and better-suited modes for care for people experiencing mental health and addiction challenges.**

   BEW Assets:

   - **Online services and telemental health services,** including crisis hotlines, are available in the BEW region, increasing the modes of access to mental health services in the communities.

   Potential areas for further intervention and assessment:

   - **Rural Outpatient Opioid Treatment** in rural Ontario is a program that integrates opioid treatment into primary care settings, offering group recovery, peer support, and opioid agonist therapy. Adaptations to the health care system, such as those through the Rural Opioid Outpatient Treatment program, can support holistic approaches to healthcare and reduce stigma around MHA challenges.

10. **Mobile crisis and rapid-access care models can meet the on-demand mental health and addictions needs of a community where specialized services may not be consistently available.**

    BEW Assets:

    - The **RCMP or police are often the first responders to crises** in communities, although there are concerns among residents about the timely response and appropriateness of police services responding to mental health and/or addictions crises.
    - **Crisis hotlines** can offer remote and private services for mental health crises and suicidality.
    - **Health centres and Recovery Alberta** (Alberta Health Services) provide acute and specialized care to people experiencing mental health and addiction crises, respectively.

    Potential areas for further intervention and assessment:

    - Rapid-Access Addictions Medicine (Manitoba)
    - Co-responder teams (police and MHA professionals) (Ontario)
    - Mobile youth crisis service (Ontario)
    - Peer-led overdose training (Quebec)

8.0. References

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