

RURAL AND REMOTE WOMEN AND THE KIRBY-KEON REPORT ON MENTAL HEALTH A Preliminary Gender-Place Analysis

Jayne Melville Whyte
with Joanne Havelock

March 2007

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centres of excellence
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Prairie Women's Health Centre of Excellence (PWHCE) is one of the Centres of Excellence for Women's Health, funded by the Women's Health Contribution Program of Health Canada. The PWHCE supports new knowledge and research on women's health issues; and provides policy advice, analysis and information to governments, health organizations and non-governmental organizations. The views expressed herein do not necessarily represent the official policy of the PWHCE or Health Canada.

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EXECUTIVE SUMMARY

The mental health of rural Saskatchewan women is threatened not only by gaps in the provision of mental health services, but more importantly by the social and economic conditions of being female in a rural setting. In Saskatchewan, women with mental illness can experience not only the social isolation and stigma of mental illness but practical considerations related to access to fewer services, especially specialists, and particular needs related to geographic distance and transportation.

The Senate Standing Committee on Social Affairs, Science and Technology Report on Mental Health, Mental Illness and Addictions, *Out of the Shadows at Last*¹ extensively documents the needs and potential direction for meaningful change in mental health services “to help bring people living with mental illness into the mainstream of Canadian society”.² This paper analyzes the *Highlights and Recommendations* of *Out of the Shadows at Last* with a gender-place lens focused on women living in rural and remote areas in Saskatchewan:

- to draw out the references that would strengthen the response to their needs, and
- to point to gaps not acknowledged in the report.

This is a preliminary analysis, intended to stimulate discussion or further research leading to implementation of positive changes in mental health services and in the determinants of mental health for women.

The authors acknowledge the particular concerns of northern and Aboriginal women, but due to the experience of the authors, this paper does have more of a focus on rural women in the southern half of the province.

¹ Kirby, The Honourable Michael J. L. Kirby, Chair and The Honourable Wilfred Joseph Keon, Deputy Chair. *Out of the Shadows at Last: Highlights and Recommendations: Final Report of the Standing Senate Committee on Social Affairs, Science and Technology*. Ottawa: Senate of Canada, May 2006. In this paper, it will often be referred to as the Kirby-Keon report or the Kirby report recognizing its chair and deputy chair.

² Kirby & Keon. *Out of the Shadows at Last: Highlights and Recommendations*, Foreword, page v.

The Three Pillars

The Kirby-Keon report laid out three pillars as the foundation for its recommendations. For rural remote and northern women, the following comments are pertinent to the Three Pillars.

- **Choice:** Lack of transportation, bad roads, travel costs and finding child care or respite care restrict the “choice” of travelling to another community or city for services. The small number of doctors and mental health practitioners limits choice for women who would prefer a female practitioner, and lesbian women seeking professionals with whom they can have a safe and comfortable relationship. Other populations, for example Aboriginal (including First Nations, Métis and Inuit women), immigrant women, or women with disabilities, also need mental health support that recognizes their particular needs and culture.
- **Community:** In communities where services are reduced by distance and small population bases, community support must be developed through coordination and creative deployment of available formal and informal resources. Their community can be a strength for rural and remote women in providing social support, but can also be a burden due to lack of privacy and stigma and lack of understanding about mental health.
- **Integration:** Integration of physical and mental health services can happen more naturally in communities with a small number of health practitioners and other professionals who talk to one another. Privacy legislation can work against information-sharing across disciplines and between services. Particular difficulties arise when services are obtained in another community without communication with the family members, doctors, home care workers and other team members in the home community. Rural and remote women also face the constant change in the service personnel that prevents continuity of care and trust-building.

Gender Analysis

A major gap with the Kirby-Keon report is the lack of specific gender analysis. Such an analysis would have led to the stronger identification of family violence, sexual abuse and other abuse as a critical factor in addressing and preventing mental health problems for girls and women. Women play major roles in the mental health system and the effects of their gender on mental health, service utilization, unpaid care-giving and paid health services work needs to be taken into account.

Priorities for Women

The Gender-Place Analysis of the Kirby-Keon report revealed several priorities for women living in rural and remote areas in Saskatchewan.

- a. Continue efforts to address the underlying causes of stress and poor health for rural and remote women: farm economy, poverty, Aboriginal issues, family violence, balancing work-family-community responsibilities, and the need for inter-generational connections and cross-cultural understanding.
- b. Provide locally-based mental health services to enable people to continue to live well in their home communities, such as local community health workers, peer support groups, respite care and other support for care-givers.
- c. Provide housing with supervision and support for people with mental health needs, enable home ownership in small communities where this is the norm, and improve housing both on and off reserves.
- d. Implement telemental health for psychiatry and psychology services and continue support for the Farm Stress Line and mental health counseling on the HealthLine, balanced with in-person services.
- e. Provide better training for the RCMP in understanding and handling mental health crises.
- f. Orient services to meet the needs of seniors, children and youth, First Nation, Métis and Inuit people.

The federal government has an opportunity to act quickly in the areas in which it has direct responsibility: First Nations and Inuit health, Corrections, the Canadian Forces, veterans, the RCMP, immigrants and refugees and the federal public service.

The Process

The following are suggested to guide the process of improving health services and the living situation of women with mental illness living in rural and remote areas in Canada.

1. As a first step, establish and fund the Canadian Mental Health Commission with the mandate to develop a strategic plan with timelines and budget to implement the recommendations of the Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last*, by Senators Kirby and Keon.
2. Use gender-place-culture lenses in all programs, services, and activities reviewed, initiated and maintained to serve the specific needs of women and men who live in rural, remote and northern communities with respect for the culture, race, and identity of all persons.
3. Evaluate the effect of any policies and services on rural, remote and northern women. Further, more detailed, work should be done on a gender-place analysis of the Kirby-Keon report and other policy and planning documents.

4. Emphasize the determinants of health approach to address factors affecting health including income, housing, social supports, education and literacy, healthy childrearing, community environments of gender and culture, as well as adequate and appropriate health services. “Health policy is more than health services.”³
5. Involve rural, remote and northern women, including Aboriginal women in the planning, management and evaluation of programs that have an impact on their lives, their families, and their mental health including the proposed Canadian Mental Health Commission and Initiatives.
6. Empower and value women in their roles as consumers of mental health services, family and friends of people with mental illness, unpaid caregivers, formal caregivers and professionals in the mental health field, policy makers and management, community and political leaders. In these often overlapping roles, they deserve personal and community support including recognition of their contribution and their right to influence and set policies.

³ Sutherns, Rebecca, et. al. *Summary Report: Rural, Remote and Northern Women's Health*. Winnipeg: Centres of Excellence for Women's Health, 2004, page 8.

INTRODUCTION

The mental health of rural Saskatchewan women is threatened not only by gaps in the provision of mental health services, but more importantly by the social and economic conditions of being female in a rural setting. The Standing Senate Committee on Social Affairs, Science and Technology Report on Mental Health, Mental Illness and Addictions, *Out of the Shadows at Last*¹ extensively documents the needs and potential direction for meaningful change in mental health services “to help bring people living with mental illness into the mainstream of Canadian society”.²

In Saskatchewan, women with mental illness can experience not only the social isolation and stigma of mental illness but practical considerations related to access to services, especially specialists, and particular needs related to geographic distance and transportation. For example, a visit to a city psychiatrist often involves fuel and food costs for travel, a day’s time for the woman and often her driver, with resulting needs for childcare, and lost time for the farm work or business.

This paper analyzes *Out of the Shadows at Last* by Senators Kirby and Keon in terms of the effect its recommendations could have on rural women. The paper reflects work done by the Centres of Excellence for Women’s Health as well as recent work by Prairie Women’s Health Centre of Excellence with rural Saskatchewan women. The purpose is to examine the Kirby-Keon report with a gender-place lens focused on women living in rural and remote areas in Saskatchewan:

- to draw out the references that would strengthen the response to their needs, and
- to point to gaps not acknowledged in the report.

¹ Kirby, The Honourable Michael J. L., Chair and The Honourable Wilfred Joseph Keon, Deputy Chair. *Out of the Shadows at Last: Highlights and Recommendations: Final Report of the Standing Senate Committee on Social Affairs, Science and Technology*. Ottawa, Senate of Canada, May 2006. <http://www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/pdf/rep02may06high-e.pdf>. In this paper, it will often be referred to as the Kirby-Keon report, or the Kirby report, recognizing its chair and deputy chair.

² Ibid., Foreword, page v.

This paper is a preliminary analysis, intended to stimulate discussion or further research leading to implementation of positive changes in mental health services and in the determinants of mental health for women.

The Centres of Excellence for Women's Health (CEWH) study entitled *Rural and Remote and Northern Women's Health: Policy and Research Directions*³ recommended that gender, place and culture be factored into all health care policy. Although rural, remote and northern regions differ, they share issues of economic uncertainty, a sense of having their needs ignored and misunderstood, and concerns about access to, and quality of, health care services. The study, based on wide consultation across Canada, also recommended that health policy be about more than health care services and should include consideration of finance, labour, social services and transportation.

Gender, and the health of women, have not typically been the focus of research, policy reviews, or health planning, and this trend continues in the current Kirby-Keon report.⁴ In anticipation of *Out of the Shadows at Last*, a working group convened by the Canadian Women's Health Network (CWHN) and the CEWH made recommendations specific to women's mental health and addictions.⁵ In particular, they noted that mental illnesses are more prevalent in women, that women utilize mental health services more frequently than men, and that women seek a wider range of treatment and support options than are currently available. The report also provided some notes regarding mental health and rural women.

Prairie Women's Health Centre of Excellence (PWHCE) and the Rural Women's Issues Committee of Saskatchewan (RWICS) have been focusing on the social and health-related needs of women in Saskatchewan. Mental health was one of the topics raised by the RWICS consultations with rural women.⁶ Additionally, women in Young,

³ Sutherns, Rebecca, et. al. *Summary Report: Rural, Remote and Northern Women's Health: Policy and Research Directions*. Winnipeg: Centres of Excellence for Women's Health, 2004.
<http://www.pwhce.ca/ruralAndRemote.htm>

⁴ See for example Sutherns, Rebecca, Maureen McCallum and Margaret Haworth-Brockman. "A thematic bibliography and literature review of rural, remote and northern women's health in Canada 2003". In press, 2006 Resources for Feminist Research.

⁵ Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions. *Women, Mental Health, Mental Illness and Addiction in Canada: An Overview*. Winnipeg: Canadian Women's Health Network and the Centres of Excellence for Women's Health, May 8, 2006.
<http://www.cwhn.ca/resources/cwhn/mentalHealth.html>.

⁶ Johns, Noreen, and Joanne Havelock. *Rural Women's Action Workshop, Carlyle, Saskatchewan*, Winnipeg: Prairie Women's Health Centre of Excellence, April 2006.
<http://www.pwhce.ca/ruralCarlyle.htm> . Reports from other workshops at http://www.pwhce.ca/program_rural.htm.

Saskatchewan⁷ asked for better diagnosis and understanding of women's health, especially depression and appropriate prescriptions. Access to formal and informal support in rural communities is an issue for persons with mental illness and their families. In addition, isolation and lack of resources contribute to the stresses that cause or exacerbate mental illness.

WHAT IS "RURAL AND REMOTE"?

The Public Health Agency of Canada defines rural and remote communities as those with populations of less than 10,000 and removed from many urban services and resources.⁸ Saskatchewan women living in these areas make further distinctions – based on whether they live on a farm, in a village or small town, in a trading centre (often with a population of 3000-4000) or in a small city (of 5000 people or more). In locations in the northern half of the province, where access may be by roads drivable only in summer, by waterways, by winter (ice) roads or by airplane, people face additional difficulties getting the services they need.

Most homes have television and radio. However, although the province has high-speed Internet in many small cities and towns, other farm and northern locations may either not have access, or be limited to dial-up Internet access, which is slow and ties up telephone lines. The days of the telephone "party line" where everyone could overhear others' conversations are gone, but there are still northern locations where radiophone is only available in a limited number of locations in the village or on the reserve, and people living in poverty or on Social Assistance may not have telephones or long distance privileges.

Residents of rural areas do not have the same health status as other Canadians. The Canadian Institute for Health Information compared health for rural and urban Canadians.⁹ Canadians living in rural areas generally have higher mortality (death) rates than those living in urban areas. The urban-rural difference was most pronounced among children and adolescents aged 5 to 19, particularly for deaths due to injuries. In Canada, the overall suicide rate was 5 deaths per 100,000 people aged 5 to 19 with rural youth having a higher risk of dying from suicide – boys were four times and girls were six times more likely to commit suicide than their urban counterparts. The risk of death in a motor vehicle accident was two to three times higher for all ages in rural areas.

⁷ Johns, Noreen. *Rural Women's Health Workshop Meetings One and Two*. Winnipeg: Prairie Women's Health Centre of Excellence, September 2004. <http://www.pwhce.ca/ruralYoung.htm>

⁸ Public Health Agency of Canada. *Rural and Remote Health Innovations Initiative*. Ottawa: Government of Canada, April 1, 2000. http://www.phac-aspc.gc.ca/rh-sr/funding_e.html#rur

⁹ DesMeules, Marie and Raymond Pong, *How Healthy Are Rural Canadians? An assessment of their health status and health determinants: A component of the Initiative "Canada's Rural Communities: Understanding Rural Health and its Determinants"*. Ottawa: Canadian Institute for Health Information, September 2006. http://secure.cihi.ca/cihiweb/products/rural_canadians_2006_report_e.pdf

A study of women living in rural, remote and northern areas of Canada found that research on their health is limited, but indicates a number of areas in which their living circumstances and health are not as good as their urban counterparts.¹⁰

ABOUT THIS PAPER

The Kirby-Keon report *Out of the Shadows at Last* is a full report with 15 chapters, and a *Highlights and Recommendations* summary. The format and headings of the *Highlights and Recommendations* document of the Kirby-Keon report form the basis for the remainder of this report. In the full document, Chapter 2 contains illustrative stories from submissions to the Senate Committee. Thus this discussion of the recommendations of the Kirby-Keon report begins with Chapter 3.

The authors acknowledge the particular concerns of northern women, but due to the experience of the authors this paper does have more of a focus on rural women in the southern half of the province – further analysis is needed for a fuller picture of the needs of northern women. The specific needs of Aboriginal women, First Nations (with and without Treaty Status), Métis and Inuit, would need further discussion as well.

¹⁰ Sutherns, Rebecca, et. al. *Summary Report: Rural, Remote and Northern Women's Health: Policy and Research Directions*, Section B: "Understanding Rural and Remote Women's Health in Canada". Winnipeg: Centres of Excellence for Women's Health, 2004, pages B5-B6.
<http://www.pwhce.ca/ruralAndRemote.htm>

Kirby Chapter 3

VISION AND PRINCIPLES

RECOVERY

One of the principles explored in the Kirby-Keon report is the concept of “recovery” for people with mental illness:

*“Recovery is not the same as being cured. For many affected individuals, recovery constitutes living a satisfying, hopeful and productive life even with the limitations caused by mental illness; for others, recovery means the reduction or complete remission of symptoms related to mental illness”.*¹¹

One of the difficulties faced by persons with mental illness is “all or nothing thinking” by the persons themselves, by their families and friends, and by their caregivers. Mental illness is often episodic with periods of severe disability and times of reduced symptoms. At times, a person can maintain many or most of the daily functions while at other times, getting out of bed seems too daunting a task. Health and support systems often do not have the flexibility to react to the changing needs of consumers. Another danger is that at less functional times, the person is blamed and shamed. Families and employers may expect a person to be either totally ill or totally well without understanding that there are many “in-between” levels of health and activity that can be enjoyed and maximized with adequate support. Recovery is a process.

In remote and rural settings where the close relatives of the person with mental illness may be the only support team, it is easy to lose perspective and set expectations too high or too low. Burnout among unsupported caregivers is also a danger when long-term chronic mental illness, with its cycles of despair and improvement, place too great a strain on relationships.

THREE PILLARS: CHOICE, COMMUNITY AND INTEGRATION

The Kirby-Keon report uses three pillars as the foundation for its recommendations:

- Choice
- Community
- Integration

¹¹ Kirby & Keon. *Out of the Shadows at Last: Highlights and Recommendations*, page 5.

Choice

Kirby talks about Choice as access to a wide range of publicly funded services and supports that offer people living with mental illness the opportunity to choose those that will benefit them most.

Choice is often limited in rural and remote centres where the family doctor or nurse practitioner in a single clinic may be the only formal resource available for mental health services. Choice is further limited when that clinic is in another community made inaccessible by lack of transportation, bad roads, the costs of travel, and the difficulty of finding child-care or respite care. If more professional services or hospital treatments are necessary, travel burdens can be excessive. Distance from families prevents regular contact to facilitate re-integration into the home and community as the person's health improves. For example, women from northern Saskatchewan who need inpatient psychiatric services must go to Prince Albert, North Battleford or Saskatoon, far from their homes and families with little opportunity even for visits from family and friends. When private therapy is most appropriate, the rural woman faces both the cost of therapy and the expense of travel.

Many women also prefer to have female practitioners but any choice of practitioners is limited by the small number of doctors and mental health workers in rural communities. Lesbian women have even more difficulty because they can face non-acceptance, discrimination, oppression and even violence in the community, and significant difficulty finding professionals with whom they can have a safe and comfortable relationship.¹² Other populations, for example Aboriginal and immigrant women, or women with disabilities, also need mental health support that recognizes their particular needs and culture.

Community

For Kirby-Keon, acknowledging Community in mental health services means making these services and supports available to the communities where people live, and orienting them toward supporting people living in the community.

Community can be either a strength or a burden for rural and remote women facing mental illness. Where there is a spirit of accepting cooperation and mutual care, rural women may be assisted in their self-care by the neighbours who provide support to the women themselves, their children and the whole family. Where stigma, fear and blame surround someone who “does not pull her own weight”, the community can further oppress and alienate the woman and her family.

¹² Ryan, Bill, Shari Brotman, Bill Rowe. *Access to Care: Exploring the Health and Well-Being of Gay, Lesbian, Bisexual and Two-Spirit People in Canada, Executive Summary*. Montreal: McGill Centre of Applied Family Studies with EGALÉ, Equality for Gays and Lesbians Everywhere, 2000, page 13. <https://home.mcgill.ca/files/interaction/summary.pdf>

Lack of childcare, limited employment opportunities and social inequalities can also be factors in conditions that cause or worsen mental stress through lack of choice and opportunity. Rural women report that in smaller communities where people recognize neighbours' vehicles and note where they are parked, there is no such thing as confidentiality. Isolation can be geographic (distance from neighbours and services) but also social (alone because of the symptoms and stigma of mental illness.)

Kirby-Keon notes that "The full range of services must be available ... to address the needs of people affected" by both serious and mild-to-moderate illnesses.¹³ In communities where services are reduced by distance and small population bases, community support must be developed through coordination and creative deployment of available formal and informal resources. When the Saskatchewan plan for health care was introduced in the 1960's the goal was that mental health services (e.g. community workers) were to be no more than an hour away from any citizen. *The Saskatchewan Action Plan for Primary Health Care* (2002)¹⁴ recommends a higher standard, that "95% of communities are within 30 minutes travel time of a primary mental health practitioner." Community mental health is one of the core services to be delivered by Regional Health Authorities through teams that would consist of family physicians, primary care nurse practitioners, home care services, public health nursing, other therapies and mental health services.

Isolation can be geographic (distance from neighbours and services) but also social (alone because of the symptoms and stigma of mental illness).

Integration

In the Kirby report, integration means integrating all types of services and supports across the many levels of government and across both the public/private divide and the professional / non- professional dichotomy.¹⁵

Integration of physical and mental health services can happen more naturally in communities with a small number of health practitioners and other professionals who talk to one another. Recent changes in privacy legislation have sometimes worked against the open sharing of information that encourages consultation across disciplines and between services. Particular difficulties arise when some services, for example psychiatric services, are obtained in another community without communication with the family members, doctors, home care workers and other team members in the home community. Another

¹³ Kirby & Keon. *Out of the Shadows at Last: Highlights and Recommendations*, page 7.

¹⁴ Saskatchewan Health, Primary Health Services Branch. *The Saskatchewan Action Plan for Primary Health Care*. Regina: Government of Saskatchewan, 2002, page 6.
http://www.health.gov.sk.ca/ps_phs_action_plan.html.

¹⁵ Kirby & Keon. *Out of the Shadows at Last: Highlights and Recommendations*, page 6.

complication faced by rural and remote women is the constant change in the service personnel who come into the community on a sporadic basis with staff turnover that prevents continuity of care and trust-building.

Kirby Chapter 4

LEGAL ISSUES

Privacy and age of consent were the focus of the first recommendations of the Kirby-Keon report.

Recommendation 1

- That the provinces and territories establish a uniform age at which youth are deemed capable of consenting to the collection, use and disclosure of their personal health information.

Recommendation 2

- That health care professionals take an active role in promoting communication between persons living with mental illness and their families. This includes asking persons living with mental illness if they wish to share personal health information with their families, providing them with copies of the necessary consent forms, and assisting them in filling them out.

Recommendation 3

- That health care professionals have discretion to release personal health information, without consent, in circumstances of clear, serious and imminent danger for the purposes of warning third parties and protecting the safety of the patient.
- That this discretion be governed by a clearly defined legal standard set out in legislation, and subject to review by privacy commissioners and the courts.

In rural communities where everybody knows everyone else's business, and where young people depend on parents or neighbours for a ride to services, privacy is difficult if not impossible to maintain.

Recommendation 4 urges the acceptance of advance directives while recommendation 5 sets up an "order of precedence" for relatives who are to be informed and involved in mental health decisions.

Recommendation 4

- That all provinces and territories empower mentally capable persons, through legislation, to appoint substitute decision makers and to give advance directives regarding access to their personal health information.
- That provisions in any provincial legislation that have the effect of barring persons from giving advance directives regarding mental health treatment decisions be repealed.

- That all provinces and territories make available forms and information kits explaining how to appoint substitute decision makers and make advance directives.
- That all provinces and territories make available community-based legal services to assist individuals in appointing substitute decision makers and making advance directives.
- That all provinces and territories undertake public education campaigns to educate persons with mental illness, and their families, about the right to appoint a substitute decision makers and make an advance directive.

Recommendation 5

- That where a person is diagnosed with a mental illness that results in his/her being found mentally incapable, and where there is no previous history of mental illness or finding of mental incapacity, and where there is no named substitute decision maker or advance directive, the law create a presumption in favour of disclosure of personal health information to the affected person's family caregiver(s).
- That the provinces and territories enact uniform legislation setting out this presumption.
- That the legislation specify an "order of precedence" for relatives (i.e., if the person is married, or living in a common-law relationship, disclosure would be to his or her spouse or common-law partner, and if there is no spouse or common-law partner, to the person's children, etc.).
- That the legislation specify the information to be disclosed, including: diagnosis, prognosis, care plan (including treatment options, treatment prescribed, and management of side-effects), level of compliance with the treatment regime, and safety issues (e.g., risk of suicide).
- That the legislation specifically bar the release of counselling records.
- That the legislation oblige the person disclosing the personal health information to notify the mentally incapable person, in writing, of the information disclosed, and to whom it was disclosed.

Gender analysis would have noted that in the case of an abusive spouse, the need for advance directives increases while sensitivity to the woman's situation and preferences may be essential to protect her from further control by her abuser.

Nothing is said in the Kirby-Keon report about the use of the Royal Canadian Mounted Police in many rural areas as first responders for people with mental illness. If a family member or a community member feels someone is in need of assessment and treatment, they can get an order from a magistrate to have the person apprehended and brought to a doctor or treatment centre. In other cases, what may be designated a crime may indeed be a cry for help. The justice system, including the RCMP, needs to recognize this difference. In these instances, there is a need to ensure adequate training and sensitivity of the officers responding to mental illness calls.

Kirby Chapter 5

TOWARD A TRANSFORMED DELIVERY SYSTEM

The Kirby-Keon report recommends a Mental Health Transition Fund to accelerate the delivery of community services (Recommendation 9) and a Basket of Community Services (Recommendation 12) that specifies the minimum range of services and supports in a community and provides funding through the Mental Health Transition Fund.

Recommendation 9

- That the Government of Canada create a Mental Health Transition Fund to accelerate the transition to a system in which the delivery of mental health services and supports is based predominantly in the community.
- That this Fund be made available to the provinces and territories on a per capita basis, and that the Fund be administered by the Canadian Mental Health Commission that has been agreed to by all Ministers of Health (with the exception of Quebec).
- That the provinces and territories be eligible to receive funding from the Mental Health Transition Fund for projects that:
 - would not otherwise have been funded; that is, projects that represent an increase in provincial or territorial spending on mental health services over and above existing spending on services and supports, plus an increment equal to the percentage annual increase in overall spending on health; and that
 - contribute to the transition toward a system in which the delivery of mental health services and supports is based predominantly in the community.
- That in allocating the resources from the Mental Health Transition Fund priority should be given to people living with serious and persistent mental illness and that a strong focus should be maintained on meeting the mental health needs of children and youth.

Adequate and affordable housing for people with mental illness would also be supported.

Recommendation 11

- That, as part of the Mental Health Transition Fund, the Government of Canada create a Mental Health Housing Initiative that will provide funds both for the development of new affordable housing units and for rent supplement programs that subsidize people living with mental illness who would otherwise not be able to rent vacant apartments at current market rates.

- That in managing the housing portion of the Mental Health Transition Fund, the Canadian Mental Health Commission should work closely with the Canada Mortgage and Housing Corporation.

The Basket of Community Services would prompt health regions to assess and augment current resources for mental health services. This could include housing, crisis and case management, and home care working together through community teamwork.

Recommendation 12

- That a Basket of Community Services that have demonstrated their value in enabling people living with mental illness, in particular those living with serious and persistent illnesses, to live meaningful and productive lives in the community be eligible for funding through the Mental Health Transition Fund.
- That this Basket of Community Services include, but not be limited to, such things as Assertive Community Treatment (ACT) Teams, Crisis Intervention Units and Intensive Case Management programs, and that the only condition for establishing the eligibility of a particular service for funding through the Mental Health Transition Fund be that it be based in the community.

A recent report from the Canadian Mental Health Association in Saskatchewan showed that most people think first of their general practitioner as a resource for mental health services.¹⁶ Recommendation 13 in the Kirby-Keon report encourages collaboration among family physicians, psychiatrists and other mental health workers as well as family members.

Recommendation 13

- That collaborative care initiatives be eligible for funding through the Mental Health Transition Fund.
- That the Knowledge Exchange Centre to be established as part of the Canadian Mental Health Commission) actively pursue the promotion of best practices in the development and implementation of collaborative care initiatives.

Caregivers or family members are usually women who may be conscripted into caring for their spouses and adult children with mental illness. Caregiving responsibilities can prevent women from getting adequate income as well as having other detrimental effects and stress.¹⁷

¹⁶ Canadian Mental Health Association in Saskatchewan. *Awareness and Access to Mental Health Services in Saskatchewan*. Prepared by INNOVA Learning, Regina, March 2006, page 4.

¹⁷ National Coordinating Group on Women and Health Care Reform. "The Charlottetown Declaration on the Right to Care". Charlottetown: CEWH, 2002. www.cewh-cesf.ca/PDF/health_reform/charlottetownEN.pdf

Recommendation 14 suggests expanding the Employment Insurance benefits to include time spent caring for family members at risk of hospitalization for mental illness.

Recommendation 14

- That compassionate care benefits be payable up to a maximum of 6 weeks within a two-year period to a person who has to be absent from work to provide care or support to a family member living with mental illness who is considered to be at risk of hospitalization, placement in a long-term care facility, imprisonment, or homelessness, within 6 months.
- That eligibility for compassionate care benefits be determined on the advice of mental health professionals and that recipients of compassionate care benefits be exempt from the two-week waiting period before EI benefits begin.

This provision is only helpful to those who pay into the EI system – farmers and the self-employed will not benefit. And there are limitations concerning the number of hours that a person is required to work, a detriment for the many women who work part-time to accommodate family responsibilities.

Recommendation 15 calls for the enhancement and diversification of respite services.

Recommendation 15

- That initiatives designed to make respite care services more widely available to family caregivers, and better adapted to the needs of individual clients as they change over time, be eligible for funding through the Mental Health Transition Fund.

Respite and support services for family caregivers (usually women) are at least as important in remote communities as elsewhere. Rural women in the RWICS project especially cited the need for respite services in caring for elderly patients and children with disabilities.¹⁸

¹⁸ See Johns, Noreen and Joanne Havelock. *Rural Women's Action Workshop, Carlyle, Saskatchewan*. Winnipeg, Prairie Women's Health Centre of Excellence. 2006.

Kirby Chapter 6

CHILDREN AND YOUTH

Schools are encouraged to be centres for child and youth mental health services in Recommendations 16, 17, and 18.

Recommendation 16

- That school boards mandate the establishment of school-based teams made up of social workers, child/youth workers and teachers to help family caregivers navigate and access the mental health services their children and youth require, and that these teams make use of a variety of treatment techniques and work across disciplines.

Recommendation 17

- That mental health services for children and youth be provided in the school setting by the school-based mental health teams recommended in previous section 6.2.1.
- That teachers be trained so that they can be involved in the early identification of mental illness.
- That teachers be given the time and the practical resources and supports necessary to take on this new role.

Recommendation 18

- That students be educated in school about mental illness and its prevention, and that the Canadian Mental Health Commission work closely with educators to develop appropriate promotion campaigns in order to reduce stigma and discrimination.

In theory, better use of schools would take advantage of the buildings and school services already available in many rural and remote areas. However, this picture is changing – many rural schools are closing, so the social infrastructure of teachers and related services will be in the larger communities, but will not be in the smaller communities. Saskatchewan women lament the school closures that have meant larger school populations in centres more distant from the children’s homes, which have resulted in more school bus time, more driving by parents to allow extra-curricular involvement, and less sense of local community and “ownership” in the school setting. There would be an opportunity to use the school buildings for other purposes if the funding can be found to pay for heat, etc and there is the local population to support other uses.¹⁹

A general shortage of child and youth services even in urban centres must be addressed in order to ensure adequate assessment and supervision of treatment in family and school settings (Recommendation 21).

¹⁹ See RWICS of Saskatchewan workshop reports at http://www.pwhce.ca/program_rural.htm

Recommendation 21

- That governments take immediate steps to address the shortage of mental health professionals who specialize in treating children and youth.

This shortage of child and youth services is even more acute in rural and northern Saskatchewan.

Tele-psychiatry is recommended by Kirby-Keon (Recommendation 22).

Recommendation 22

- That the use of tele-psychiatry be increased in rural and remote areas, to facilitate the sharing of mental health personnel who specialize in treating children and youth with these communities.
- That tele-psychiatry be employed both for consultations and for the purposes of education and training of health professionals who work in rural and remote areas.

For conditions requiring comprehensive assessment and treatment, the use of tele-psychiatry, where health care providers may interview clients from a distance through the use of a video monitor, may help provide additional access to services. But it needs to be supplemented with in-service training for the families, teachers and other personnel to carry out the individual therapy plans. One of the strengths of tele-psychiatry would be the ability to consult psychiatrists for client assessment that could be followed up by community mental health workers. Consultations with psychiatrists and psychologists by telephone and video-cam would offer support and guidance for the community workers including family doctors who are often the first or only professional consulted. This would benefit children and youth, seniors and the general population, since psychiatric consultants are rarely available to travel to the rural and remote communities.

Saskatchewan for a number of years has had a Farm Stress Line, where men and women call with a range of financial and personal concerns. A telehealth information line with access to trained nurses has recently been instituted in the province.

Kirby Chapter 7

SENIORS

As young people move to the cities for education and jobs, the proportion of seniors in rural Canada increases. As well, we are approaching an imminent increase in the number of older adults as the post-WWII “baby boom” become pensioners.

In rural areas, more women than men are seniors. Both physical and mental health needs must be addressed simultaneously, ideally in their own homes and community in ways that meet the needs of daily living and prevent isolation and loneliness. RWICS participants also noted the need for intergenerational activities that promote connectedness.²⁰

Recommendation 27 urges that money from the Mental Health Transition Fund be used to provide supports that allow seniors with mental illness to continue living in the community.

Recommendation 27

- That money from the Mental Health Transition be made available to the provinces and territories for initiatives designed to facilitate seniors with a mental illness living in the community; these initiatives could include, amongst other things, the provision of:
 - home visits by appropriately compensated mental health service providers;
 - a range of practical and social support services delivered in their homes to seniors living with mental illness;
 - a level of support to seniors living with mental illness that is, at a minimum, equivalent to the level of support available to seniors with physical ailments, regardless of where they reside;
 - a more widely available supply of affordable and supportive housing units for seniors living with mental illness.

Services must be prepared to fund the extra staff time and travel necessary to support rural families in the communities where they live. When city consultations are necessary, arrangements for travel and support for seniors may need to be considered as part of the health care package. Centralization of services saves money for the health care systems but off-loads the cost onto individuals.

Recommendation 28 would reduce the stress and burnout caused by expectations placed on family to provide the extra care for physical and emotional needs of someone with mental illness.

²⁰ Ibid.

Recommendation 28

- That seniors with mental illness who are living with family caregivers be eligible for all of the health and support services that would be available to them if they lived alone in their own home.

Participants in RWICS workshops also noted the need for recognition of caregivers, including neighbours in small towns that perform a variety of household tasks and errands for others. It is also worth noting that most of the care providers in home care and institutional care are women, and a gender analysis should be undertaken in workforce planning and management.

A “*professional service navigator*” is suggested although no recommendation is made to mandate such a role in the mental health system.²¹ The “navigator” would be an asset to rural residents in ensuring that various appointments, tests and reports would be consolidated to reduce travel time, expense and disruption to daily lives. A recommendation for a patient guide to help people sort through the maze of medical visits and hospital care generally was recommended by RWICS at the workshop in Young, Saskatchewan. RWICS participants also noted the need for better coordination of appointments and diagnostic tests.

Recommendation 29 advocates clinically appropriate mental health services for residents in long-term care facilities.

Recommendation 29

- That efforts be made to shift seniors with a mental illness from acute care to long-term care facilities, or other appropriate housing, where it is clinically appropriate to do so, by making alternatives to hospitalization more widely available.
- That staffing competencies in long term care facilities be reviewed and adjusted, through the introduction of appropriate training programs, to ensure that the devolution of responsibility for patients living with a mental illness from acute care facilities to long-term care facilities is done in a way that ensures that clinically appropriate mental health services are available to residents on-site.

Tele-psychiatry could be a valuable tool in working with seniors in rural and remote areas. Additional training for management and staff are necessary before they will feel confident and competent in caring for people with mental illness.

Kirby-Keon Recommendation 30 suggests that a range of institutionally-based services be integrated by locating them adjacent to each other to makes the transition(s) between different institutional settings efficient and safe. It also urges that every effort be made to allow couples to live together or in close proximity.

²¹ Kirby & Keon. *Out of the Shadows at Last: Highlights and Recommendations*, page 25.

Recommendation 30

- That a range of institutionally based services for seniors living with a mental illness be integrated (e.g., supportive housing units and long term care facilities) by locating them adjacent to each other, to make the transition(s) between different institutional settings efficient and safe.
- That every effort be made to facilitate aged couples being able to continue to live together, or in close proximity to one another, regardless of the level of services and supports that they each may require.

In rural communities, this may mean changing the levels of staffing support in either their home or long-term care facility while allowing the senior to remain in familiar settings.

Kirby Chapter 8

WORKPLACE AND EMPLOYMENT

The Kirby-Keon report states the importance of reducing factors in the workplace that have a detrimental effect on mental health and strategies to improve the ability of individuals to adapt to and manage stress.

Recommendations 31 and 32 point to the need to develop and publicize best management practices to encourage mental health in the workplace.

Recommendation 31

- That the Canadian Mental Health Commission work with employers to develop and publicize best management practices to encourage mental health in the workplace.

Recommendation 32

- That the Knowledge Exchange Centre to be created as part of the Canadian Mental Health Commission assist employers, occupational health professionals and mental health care providers in developing a common language for fostering the management of mental illness in the workplace and in sharing best practices in this area.

Implementation of Recommendation 31 must consider that farm families, small business owners, and homemakers live and work in the same setting without “employers”. Workplace supports and/or home support must work together to improve mental health and support caregivers for people with mental illness, recognizing that income, as well as daily living, is affected.

In addition, farm work often means long hours, which for women may encompass homemaking, childcare, elder care, farm work including driving heavy equipment, farm financial management, driving to town to get machine parts, and more and more often the women are also engaged in off-farm employment. Lack of childcare means that farmwomen often must take their infants and toddlers with them in the truck or farm machinery, or leave them with older siblings. This increases stress of the mother and increases the danger of accidents, injury and even death for the children.

Balancing work, family and community responsibilities is a major source of stress for many women and especially farmwomen.²² The decline in population in many rural areas has placed a greater burden on those women remaining to maintain community organizations.

In working with employers, consideration should be made for the type of employers most commonly found in rural and remote areas: small businesses, public services, local or Band government, as well as employees in smaller operations or regional offices linked to larger businesses and organizations. The needs of women in rural, remote, farm and self-employment situations may require research and education that differs from what is often thought of as occupational health and safety. This contributes to a sense of disempowerment that negatively affects mental health. Unfortunately, women's perspectives have not been sought and factored into many decisions regarding rural and agricultural policies.²³

The Kirby-Keon report addresses the issue of Canada Pension Plan - Disability benefits.

Recommendation 37

- That the eligibility criteria for Canada Pension Plan — Disability (CPP-D) benefits be modified so that persons living with a mental illness are no longer required to demonstrate that their illnesses are severe and prolonged, but only that their illness has been diagnosed and that they are unemployable and need income support.
- That the Government of Canada review how to coordinate better Employment Insurance (EI) sickness benefits and CPP-D, and examine how to eliminate structural barriers (i.e., financial disincentives) that limit opportunities to return to work.
- That the Government of Canada grant authority to the CPP to permit it to sponsor research on, and the testing of, new approaches that could target people with episodic disabilities, particularly episodic mental illness.
- That the Government of Canada explore ways to provide incentives to employers who hire persons living with mental illness, including the possibility of offering them CPP premium “holidays”.

The benefit of this recommendation is limited for rural women with mental health difficulties. In general, women with poor mental health face multiple jeopardy in building

²² Allen Julia. “Farm Women Speak Out About Stress”. An article about the work of Wendee Kubik with farm women. *Network Magazine*, Winter 2003, Volume 5/6, Number 4/1. Winnipeg: Canadian Women's Health Network. <http://www.cwhn.ca/network-reseau/6-1/6-1pg5.html>. See <http://www.cprc.uregina.ca/history.htm> re Kubik's theses: *The Research and Study of Farm Stress and Coping: A Critical Evaluation* (1996) and *The Changing Roles of Farm Women and the Consequences for their Health, Well-being and Quality of Life* (2004).

²³ See Roppel, C., A.A. Desmarais and D. Martz. *Farm Women and Canadian Agricultural Policy* by Carla Roppel, Annette Aurélie Desmarais and Diane Martz. Ottawa: Status of Women Canada, April, 2006. http://www.swc-cfc.gc.ca/pubs/pubspr/0662430093/index_e.html

CPP equity, being women in the unpaid or underpaid workforce, and interruptions in employment because of mental illness. Rural and remote women are also likely to be self-employed or farmers and have fewer employment opportunities because of geography. In recent years employment opportunities have become even more limited in many rural areas, especially as hospitals and schools that have traditionally employed a large proportion of women have been closed or centralized to other locations.

The difficulty of getting medical assessment for disability benefits such as the Disability Tax Credit also increases in rural areas with limited access to doctors and specialists. A gap in the Kirby-Keon report is that it does not address the mental health concerns of the self-employed or farmers. Self-employed people, including farmers, must contribute their own and the employer's share to CPP. Farm women can only contribute to CPP if they have off-farm employment meeting the minimum annual contribution level (currently earnings of \$3500 per year), or if they income-split with their spouse and the farm earns enough to meet the \$3500 level and provides enough income to allow them to make a contribution. In Saskatchewan women can also contribute to the Saskatchewan Pension Plan, if they have the funds. The net result is that self-employed and farm women often are not part of CPP or will not get significant payments from it, either on their own or as part of spousal survivor benefits. This contributes to poverty in old age and is detrimental to the women's stress levels and health.

Although they may be in a situation of "negative income" (debt) because of high input costs and low prices for their crops, in times of need, farmers are not eligible for social assistance because they own property. Because of the nature of their self-employment, they are not always eligible for programs that supplement the incomes of low income working people. Use of a Food Bank means traveling to an urban centre and facing the stigma of visible poverty, but farmers in Saskatchewan are using Food Banks in spite of these drawbacks. The South East Rural Resource Committee, concerned about the stresses on farm families offers referrals, information, mental health counseling, advocacy and financial assistance. Financial aid is dispensed through the Neighbours Helping Neighbours Fund to assist struggling farm families in the southeast with utility costs when cut-off of services is imminent.²⁴ When mental illness affects the farmer (male or female), extra costs, reduced ability to maintain necessary functions for home and work, and reduced income present additional economic stresses.

A question has been raised whether depression and anxiety in rural women is a mental health problem or a reasonable response to the conditions under which many farm women live.²⁵ In other words, is it a personal or social, political problem? And if it is

²⁴ Kerr, Shirley. "Regrowing Saskatchewan: farm families are pulling together to find solutions to the challenges they face". Regina: *Briarpatch Magazine*, November 2002.
http://www.findarticles.com/p/articles/mi_m0JQV/is_9_31/ai_94207132

²⁵ Gerrard, Nikki. "Mislabeling Anxiety and Depression in Rural Women", Chapter 17 in Paula J. Caplan, *Bias in Psychiatric Diagnosis*. Lanham, USA: Rowman & Littlefield Pub Inc, October 2004.
<http://booksmatter.com/b0765703750.htm>

indeed more related to the circumstances, is it appropriate to treat the individual without addressing the cause? In her article, Saskatchewan researcher and mental health clinician Nikki Gerrard lists stressors for farm women, particularly the fact that currently about half of the family farms are not viable in the present economy; farm women live thirty miles from their nearest neighbour, store or doctor; women take responsibility for field work, homemaking, child care and off the farm employment; wives and daughters often lack decision-making power on the farm; and programs for farm women have been eroded. It is ironic that women can so frequently be given medicines to address their mental condition that may reduce their ability to think and function, but the women do not have opportunity or resources to change their living conditions.

The Farm Stress Line in Saskatchewan was established in 1992, partly in response to the increasing number of bankruptcies and farmer suicides, to provide farmers a place to call regarding financial and personal problems and access to services. Women comprise 50-55% of callers, often calling out of concern for others in their family.²⁶

²⁶ Saskatchewan Agriculture and food "Farm Stress Line".
http://www.agr.gov.sk.ca/programs_services/farmstressline.asp

Kirby Chapter 9

ADDICTION

The first step in addressing addictions is in preventing them, and having an informed community that can identify and take steps to address developing addiction problems at an early stage. The community's support is critical in improving and sustaining more healthy lifestyles.

In dealing with addictions, as with mental illness, the front line health care worker, usually the family doctor/ general practitioner needs to be aware and willing to diagnose and make proper referrals for help. In smaller communities, this may also include awareness of self-help resources in the community and sensitivity to the stigma of getting help.

In 1996 a Health Canada report, *Rural Women and Substance Use: Issues and Implications for Programming*²⁷ pointed to issues such as the status and role of rural women, the effects of geography, time and distance, social isolation, family violence, lack of health care and child care services as factors in women's addiction and recovery.

The Kirby-Keon report states that people who are poor, marginalized or otherwise disadvantaged suffer disproportionately from addictions, including problem gambling. It calls for specific attention to First Nations, Métis, and Inuit peoples. This is one point in the report where women are mentioned specifically (along with youth and children, seniors, and those affected by Fetal Alcohol Spectrum Disorders).

Recommendation 43

- That the Government of Canada conduct an assessment of the outcomes of existing programs dedicated to addiction problems for First Nations, Inuit and Métis peoples.
- That the results of this assessment be shared through the Knowledge Exchange Centre to be created as part of the Canadian Mental Health Commission (see Chapter 16) with a view to identifying successful treatment models and expanding these programs to improve access and reduce wait times.
- That the provinces and territories develop and implement evidence based outreach, and primary and secondary prevention programs for at-risk populations — women, children and youth, seniors, and those affected by Fetal Alcohol Spectrum Disorders.

²⁷ Health Canada. *Rural Women and Substance Use: Issues and Implications for Programming*, 1996. Cat. No. H39-364/1996E http://www.hc-sc.gc.ca/ahc-asc/pubs/drugs-drogués/rural_women-femmes_rurales/index_e.html

Substance abuse often interacts with psychiatric symptoms. Substance use and abuse (legal, illegal, and prescribed) can mask, or worsen, the symptoms of a mental illness. As well as dealing with the substance abuse, practitioners must assist with the psychiatric illness and the person's living situation.

Family doctors are on the front lines in the diagnosis and intervention of mental illness and addictions. Recommendation 44a deals with their role is FASD diagnosis and Recommendation 44b of the Kirby-Keon report calls for funding for outreach, treatment, prevention programs and services with concurrent disorders.

Recommendation 44a

- That family physicians be trained, through medical school and professional development curricula, on diagnostic guidelines for Fetal Alcohol Spectrum Disorders (FASD) in the use of brief intervention and interview techniques to recognize problem substance use leading to addiction.
- That family physicians be trained, through medical school and professional development curricula, on diagnostic guidelines for Fetal Alcohol Spectrum Disorders (FASD).

Recommendation 44b

- That the Government of Canada include as part of the Mental Health Transition Fund \$50 million per year to be provided to the provinces and territories for outreach, treatment, prevention programs and services to people living with concurrent disorders.

The report also states that because of the overlap of causes and effects of addictions and mental illness, there is need and opportunity for the two sectors to work together and possibly integrate the services (Recommendation 45).

Recommendation 45

- That the Canadian Mental Health Commission actively partner with national addiction organizations, and work toward the eventual goal of integration of the addiction and mental health sectors.

Some provinces, including Saskatchewan, are already working toward the integration of the addiction services and mental health services. Because these two systems have had different approaches to treatment and self-help, steps toward integration need to ensure that the strengths of each service is maintained.

Gender based analysis notes that men often self-medicate with alcohol or illicit drugs while women are more likely to use prescribed medications.²⁸

²⁸ Poole, Nancy, British Columbia Centre of Excellence for Women's Health, and Colleen Anne Dell, PhD., Canadian Centre on Substance Abuse, *Girls, Women and Substance Use*. 2005.
<http://www.ccsa.ca/NR/rdonlyres/628CF348-1B92-45D5-A84F-303D1B799C8F/0/ccsa0111422005.pdf>

The Health Canada *Rural Women and Substance Abuse* report identified that women who misuse alcohol are most often living with stress, often related to relationship problems, traumatic life events such as sexual abuse and violence, day-to-day stresses such as lack of support for child care as well as underlying mental health problems of depression or anxiety. Isolation may be cause or effect, as women often drink at home alone and hide problematic drinking. Women's alcohol problems are often denied and because of the stigma of using services, women avoid asking for help until there is a crisis. Availability of appropriate services, entrance restrictions and waiting lists are significant barriers to getting help even when the problem is identified.

Kirby Chapter 10

SELF-HELP AND PEER SUPPORT

In small communities where everyone knows each other's business, there is an opportunity for increased community support when an individual or family is facing crisis. On the other hand, protecting one's privacy can prevent asking for the help needed. The probability that someone you know will see you at the doctor or recognize your vehicle at the mental health clinic deters some people from using services. Overlap of social and self-help relationships may discourage openness about one's real issues.

Programs to develop leadership capacity among persons with mental illness, and their families are suggested (Recommendation 46 and 47).

Recommendation 46

- That programs be put in place to develop leadership capacity among persons living with mental illness, and their families.
- That the Knowledge Exchange Centre (see Chapter 16) contribute to building this capacity by facilitating electronic access to information and technical assistance for people affected by mental illness and their families.

Recommendation 47

- That funding be made available through the Mental Health Transition Fund that is specifically targeted at:
 - increasing the number of paid peer support workers in community-based mental health service organizations.
 - providing stable funding to strengthen existing peer development initiatives, build new initiatives (including family groups), and build a network of self-help and peer support initiatives throughout the country.
- That the federal government lead by example, building on innovations such as the National Peer Support Program for current and former Canadian Forces members and support, with appropriate levels of funding, self-help and peer support programs for the client groups that fall under the jurisdiction of the federal government.

When these programs are put in place priority must be given to ensuring that opportunities are created for women in rural and remote settings and that suitable core funding and support is maintained to ensure the success and continuity of the self-help initiatives. People dealing with emotional and mental health conditions need administrative support, and rural women doing a triple workload already don't have the time to maintain organizations. The Saskatchewan Women's Agricultural Network in a study funded by Prairie Women's Health Centre of Excellence pointed out that federal and provincial farm women's support has eroded in recent years and that the funding cutbacks have reduced the opportunities for rural women to come together to learn, to

support one another, and to influence public policy.²⁹ This factor was also stressed in recent RWICS workshops in seven rural Saskatchewan locations.³⁰

²⁹ Gerrard, Nikki and Gwen Russell. *An Exploration of Health-related Impacts of the Erosion of Agriculturally Focussed Support Programs for Farm Women in Saskatchewan*. Saskatoon: Prairie Women's health Centre of Excellence, 1999.
http://www.uwinnipeg.ca/admin/vh_external/pwhce/explorationHealthRelated.htm

³⁰ See RWICS reports at http://www.pwhce.ca/program_rural.htm

Kirby Chapter 11

RESEARCH

Research is often conducted in urban centres, usually university cities. In order to recognize and meet the differing needs of persons in rural and remote communities, attention must be paid to collecting and analyzing results based on community size and distance from professional services. Rural women have felt invisible because so little research is gender-place specific.³¹

The Saskatchewan Health Research Foundation identified rural and remote health services as a research priority in province-wide consultations in 2004. In April 2006 they published a discussion paper *Rural and Remote Health Services in Saskatchewan: Identifying Research Priorities*.³²

The SHRF paper points out a number of key issues for rural people, beginning with the fact that approximately 36% of Saskatchewan residents live in rural and remote regions of the province, significantly more than the Canadian average of 20%. The discussion paper notes difficulties in obtaining prevention services like immunization, information and advice, and health services, including services at home. Hospitalization for preventable conditions tends to be higher in rural areas. Satisfaction with physician services is generally lower. Agriculture has been identified as one of the most dangerous occupations because of hazardous working conditions. Compared to the national average, a smaller proportion of people living in rural remote regions rated their health as “excellent.” The SHRF discussion paper does not have a mental health focus and unfortunately does not recognize the need for gender analysis.

Cooperation with other agencies and governments is recommended by Kirby and Keon to the Public Health Agency of Canada when developing its national mental illness surveillance program (Recommendation 62).

Recommendation 62

- That the Public Health Agency continue its efforts to develop in a timely way a comprehensive national mental illness surveillance system that incorporates appropriate privacy provisions.

³¹ Sutherns, Rebecca, et. al. *Summary Report: Rural, Remote and Northern Womens Health* , page 6.

³² Saskatchewan Health Research Foundation, *Rural and Remote Health Services in Saskatchewan: Identifying Research Priorities*, Saskatoon, April 2006.
<http://www.shrf.ca/adx/asp/adxGetMedia.asp?DocID=6318,6248,6233,2,Documents&MediaID=4569&Filename=R+%26+R+Discussion+Paper.pdf>

- That the Public Health Agency expand the range of data collected in cooperation with other agencies, such as the Canadian Institute for Health Information and Statistics Canada, as well as other levels of government and organizations that collect relevant data.
- That, as it develops a comprehensive national mental health surveillance system, the Public Health Agency work with the Canadian Mental Health Commission.

In addition to cooperation with other agencies and governments, the Centres of Excellence for Women's Health and the Canadian Women's Health Network should be included in the development and implementation of the research and analysis of results.

Kirby Chapter 12

TELEMENTAL HEALTH

The recommendation to develop the infrastructure and expertise for telemental health is specifically aimed at rural and remote communities.

Recommendation 67

- That the Knowledge Exchange Centre work with the provinces and territories, as well as with other bodies such as the Canadian Institute for Health Information, in order to measure the cost-effectiveness of telemental health care delivery compared to traditional mental health service delivery.
- That the Knowledge Exchange Centre assist in the development of evaluation tools for telemental health services.

While technology is important, face-to-face human interaction is often essential in building the therapeutic relationship that encourages a person to stay on a medication regime or therapy. The use of community mental health workers, who have access to consultation with psychiatrists and other professionals, is one way to meet this need. These workers include health professionals such as Registered Psychiatric Nurses and social workers who have a particular interest and training in mental health. Telehealth also does not change the reality that every community needs emergency and crisis response, including suicide prevention intervention personnel.

Recommendation 68

- That the Canadian Mental Health Commission encourage the inclusion of telemental health instruction in medical schools, and that it work with the provinces and territories, as well as with the relevant professional bodies, to make information available on telemental health to current mental health providers through its Knowledge Exchange Centre.

In Saskatchewan, the HealthLine provides information and offers first-aid counseling for mental illness. The Farm Stress Line offers support and counseling for both men and women in rural areas and has an active role in supporting farm families during personal and agricultural crisis times. The Farm Stress Line also has the Connections directory of organizations and services in rural Saskatchewan.

However there are still northern areas that can only be reached by radiophone. Many poor people do not have a phone, so must borrow someone else's phone making confidentiality a greater problem. Social services does cover basic telephone, but not long distance, so poor clients would only be able to call a toll-free line. But even if basic services are covered, not everyone is able to provide the necessary down payment to receive telephone services.

Public access to computers at libraries and schools has allowed rural communities to connect with the Internet and its many resources for information and communication, both for personal services and health research and training and developing economic opportunities. However, using public access has attendant fears about confidentiality about topics researched and studied on computers that others can see. Women have been slower to embrace computer use although they are catching up, yet many do not have the time to learn to use the computer or to spend on searching for information. Electronic media such as the Internet may have limitations in serving the needs of persons with mental illness who may lack literacy skills including computer skills to access the resources. In addition, many areas still do not have high-speed Internet. On the other hand, the computer has proven to be an important point of communication and information for people who live at a distance from friends, libraries, and other resources. Rural women are concerned about the cuts to funding for the Community Access Program that support Internet access in libraries and other public spaces.³³

It should be noted that the Saskatchewan Communication Network (SCN) has been effective in broadcasting training for professionals and community leaders through its network with local sites that are often located in the regional colleges and libraries of rural Saskatchewan as well as university settings. Use of local facilitators has allowed discussion and feedback as part of the televised presentations.

³³ TeleCommunities Canada. "Government Cuts CAP Communities Program". September 2006. <http://www.tc.ca/>

Kirby Chapter 13

THE FEDERAL DIRECT ROLE

The federal government has significant responsibility for programs and services related to the mental health, mental illness and addictions of First Nations and Inuit, federal offenders, Canadian Forces members, veterans, RCMP members, immigrants and refugees, and federal public service employees.

Recommendation 86 asks the federal government to develop a strategy including goals and timelines for mental health taking into account each group's particular needs.

Recommendation 86

- That the federal government develop a strategy for mental health that is inclusive of all federal client groups and that takes into account each group's particular needs;
- That the strategy set goals, including a timetable for implementation and for subsequent evaluation;
- That the strategy have as its objective making the federal government a model employer as well as model provider with respect to its various clients.

Recommendation 87 asks for a report to Parliament in 2008 on what precisely the federal government is doing to implement a population health approach addressing economic, educational, occupational and social factors that have an impact on the mental health of all federal clients.

Recommendation 87

- That the mental health strategy to be developed by the federal government incorporate a population health approach to the determinants of mental health, and that it specifically address the economic, educational, occupational and social factors that have an impact on the mental health of all federal clients;
- That the federal government report to Parliament in 2008 on what precisely it is doing to implement a population health approach for federal clients.

The Kirby-Keon recommendations for each of these populations contain specific, actionable guidelines to address appropriate interventions for prevention and treatment of mental illness.

FIRST NATIONS AND INUIT

For First Nation and Inuit people, Recommendation 69 urges a federal entity, under the leadership of an Aboriginal person, with the authority to investigate individual complaints and systemic areas of concern and report annually to Parliament.

Recommendation 69

- That the federal government establish a federal entity for First Nations and Inuit clients, similar to the Correctional Investigator, the Canadian Forces Ombudsman, or the RCMP External Review Committee;
- That this entity be authorized to investigate individual complaints as well as systemic areas of concern related to federal provision of programs and services that have an impact on the mental wellbeing of First Nations and Inuit;
- That the person responsible for this entity be, if possible, of aboriginal origin;
- That this entity provide an annual report to Parliament.

A further recommendation (71) urges an independent study into the federal provision of programs and services relevant to the overall health of First Nations and Inuit.

Recommendation 71

- That the federal government immediately establish an independent study into the federal provision of programs and services relevant to the overall health of First Nations and Inuit;
- That this study examine various alternatives for the provision of these services; provide clear assessments of these alternatives; and present a comprehensive report with recommendations to Parliament in 2008.

Note that these do not specify services for Métis women, who the federal government has not considered as falling within federal responsibility for health services. First Nations women without Treaty Status would also not necessarily benefit from federal services.

Involvement and leadership from First Nation and Inuit women must be solicited to ensure their voices are heard in planning and implementing mental health services. In a response to the Canadian Aboriginal Peoples' Roundtable, the Native Women's Association of Canada (NWAC) makes a case for inclusion of First Nation, Métis, and Inuit women using gender-based analysis in all negotiations. NWAC's goal is to enhance, promote and foster the social, economic, cultural and political well-being of First Nations and Métis women. NWAC works collaboratively with the Pauktuutit Inuit Women's Association that sets forth distinct needs and perspectives of Inuit women.³⁴

CORRECTIONAL SERVICES

For Federal Offenders, the Correctional Service Canada is directed to develop and implement standard of care guidelines for mental health within institutions and in post-release settings (Recommendation 72):

³⁴ Native Women's Association of Canada, *Alternative Report: Follow Up to the Sectoral Sessions, Canada Aboriginal Peoples' Roundtable (CAPR)*. Ottawa: Native Women's Association of Canada, May 2005, pages 3-4.

Recommendation 72

- That Correctional Service Canada (CSC) develop and implement standard of care guidelines for mental health to be applied within institutions and in post-release settings that are equivalent to those applied in settings accessed by the general population.
- That CSC guidelines be based on the collection of statistical information about federal offenders and their mental health disorders and addictions, including prevalence rates for mental health disorders, type of treatment utilized (psychotherapy, medication, etc.), rate of hospitalization, etc.
- That CSC performance with respect to implementing the guidelines be reviewed annually by an independent external body with mental health expertise such as the Canadian Mental Health Commission.
- That data used for the guidelines be compiled and made available to the public and that the raw data be made available to researchers for independent analysis.
- That the performance assessment be reported to Parliament annually starting in 2008.

Full clinical assessment within seven days of arrival, training of correctional officers, provision of psychotherapy, and increased capacity for treatment (Recommendation 73) and a case management system (Recommendation 74) are measures to improve ongoing treatment and care of inmates.

Recommendation 73

- That Correctional Service Canada conduct a full clinical assessment by an accredited mental health professional of each offender to determine their mental health and/or addiction treatment needs to be completed no later than seven calendar days after their arrival at a reception centre.
- That Correctional Service Canada undertake training of correctional officers and other staff immediately following their appointment to enable them to distinguish between a mental health crisis and a security crisis.
- That Correctional Service Canada make psychotherapy available to offenders, when medically necessary, provided by a psychiatrist, psychologist, clinical social worker or other health care professional who is not responsible for the risk assessment of offenders.
- That Correctional Service Canada increase the capacity of its existing treatment centres with additional beds as well as additional staff.
- That Correctional Service Canada immediately implement expanded harm reduction measures in all federal correctional institutions.

Recommendation 74

- That Correctional Services Canada establish a case management system that ensures that offenders have access to appropriate mental health treatment upon their release, including a requirement to supply, without cost, enough medication to last until their transition to provincially or territorially provided community-based care.

The specific needs of female prisoners, including their concerns for their children, should not be overlooked in the assessment and treatment of inmates. NWAC quotes a Canadian

Human Rights Commission (2003) study that indicates women prisoners have higher rates of mental illness, self-abuse (such as slashing and cutting) and suicide attempts.³⁵ NWAC also notes that while Aboriginal women make up 3% of the Canadian female populations, they make up 29% of the prison population.

CANADIAN FORCES

The Canadian Forces have initiated new mental health programs and services that need to be evaluated including services for post-traumatic stress disorder and addictions (Recommendation 77).

Recommendation 77

- That National Defence evaluate and report to Parliament on the programs and services currently available to Reservists for mental health problems resulting from their duties while mobilized, including services for post-traumatic stress disorder and addictions.

The introduction of women as full members of armed forces in combat zones offers an opportunity to study and respond to their particular experiences.

Veterans Affairs Canada provides community-based mental health care services beyond those provided under provincial and/or territorial plans. Recommendation 78 calls for an annual inventory of programs and services for veterans for mental health to be reported to Parliament.

Recommendation 78

- That Veterans Affairs Canada in conjunction with National Defence prepare an annual inventory of programs and services for mental health, including the number of clients served, the funding allocated and spent, and the outcomes achieved.
- That the report be tabled in Parliament annually starting in 2008.

Kirby-Keon also recommends an entity to investigate individual complaints and systemic areas of concern that have an impact on the mental well-being of veterans (Recommendation 79).

³⁵ Canadian Human Rights Commission, *Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women*. Ottawa: Canadian Human Rights Commission, 2003, page 8. Quoted in *The Native Women's Association of Canada Background Document on Aboriginal Women's Health for the Health Sectoral Session, Following Up to the Canada-Aboriginal Peoples Roundtable*. Ottawa: Native Women's Association of Canada, October 2004.

Recommendation 79

- That the Government of Canada establish an entity for veterans, similar to the Correctional Investigator, the Canadian Forces Ombudsman, or the RCMP External Review Committee;
- That this entity be authorized to investigate individual complaints as well as systemic areas of concern related to federal provision of programs and services that have an impact on the mental wellbeing of veterans;
- That this entity provide an annual report to Parliament.

Many veterans, both male and female, continue to live in rural communities so these services would need to consider rural concerns.

ROYAL CANADIAN MOUNTED POLICE

For the Royal Canadian Mounted Police (RCMP), the recommendations include funding for a mental health and addictions training program for members and the use of peer counseling for post-traumatic stress. Recommendation 80 also asks the RCMP to make public the results of the RCMP task force looking at RCMP disability, and the need for programs and services. It also calls for an annual inventory of programs and services to be reported to Parliament.

Recommendation 80

- That the federal government fund a mental health and addictions training program aimed at RCMP members.
- That the RCMP make public as soon as possible in 2006 the results of the ongoing analysis by the RCMP task force looking at RCMP disability and the need for programs and services.
- That the RCMP establish the use of peer counselling for RCMP members following the DND/VAC model for post-traumatic stress.
- That the RCMP include these initiatives and other programs and services in an annual inventory on programs and services for RCMP officers.
- That the inventory be reported to Parliament annually starting in 2008.

The RCMP External Review Committee is asked to do an analysis of the mental health needs of RCMP members and RCMP veterans to be reported to Parliament by 2008 (Recommendation 81).

Recommendation 81

- That the RCMP External Review Committee do an analysis of the mental health needs of RCMP members and RCMP veterans and report to Parliament by 2008.

In performing their duties, the role of RCMP as first responders in a crisis means that they are often called on to make a judgment whether an incident is a crime or a symptom of mental illness, and to have the skills needed to defuse emotional situations in rural communities. Additional training for The RCMP in handling mental health crises would

prepare them better and lead to improved handling of mental health crises situations, as mentioned earlier in this paper.

IMMIGRANTS AND REFUGEES

Citizenship and Immigration covers essential and emergency mental health services for immigrants and refugees who are unable to pay for them privately.

Recommendation 82 calls for an entity to investigate individual and systemic concerns related to the federal provision of programs and services that influence the mental wellbeing of immigrants and refugees. It also calls for an annual report and an annual inventory of programs and services.

Recommendation 82

- That the federal government establish an entity for immigrants and refugees, similar to the Correctional Investigator, the Canadian Forces Ombudsman, or the RCMP External Review Committee;
- That this entity be authorized to investigate individual complaints as well as systemic areas of concern related to federal provision of programs and services that have an impact on the mental wellbeing of immigrants and refugees;
- That this entity provide an annual report to Parliament.

Recommendation 83 recognizes the importance of adequate funding for language training for the diverse populations.

Recommendation 83

- That Citizenship and Immigration Canada provide an annual inventory to Parliament on its programs and services relevant to mental health, including clients served, expenditures allocated and spent, and outcomes achieved, starting in 2008.
- That Citizenship and Immigration Canada increase funding for and access to language training by diverse groups through increased training allowances, appropriate scheduling of instructional hours, and the location of classes in places that facilitate access.

Although many immigrants tend to settle in cities, there are some that begin their Canadian lives in rural areas. Many move to cities after a period of time. This is often true of health professionals recruited to solve gaps in services in rural areas. As Saskatchewan strives to increase the recruitment and retention of immigrants to the province, these considerations will be important, and a gender analysis of settlement services will be invaluable. A report by Prairie Women's Health Centre of Excellence noted that immigrant women need language training, and that ESL language instructors

may need to be aware of the effects of Post Traumatic Stress Syndrome on many of the women who are refugees and immigrants in Canada.³⁶

FEDERAL PUBLIC SERVICE

The Federal Public Service consists of an estimated 450,000 employees across Canada. The Kirby-Keon report recommends a model for coordinating interdepartmental mental health policies, programs and activities for employees, forming partnerships with other sectors to stimulate and facilitate the exchange of best practices in the support of workplace wellbeing, and develop strategies to reduce and eliminate the stigma attached to mental illness (Recommendation 84).

Recommendation 84

- That the federal government draw upon the model established by the Global Business and Economic Roundtable on Addiction and Mental Illness in coordinating interdepartmental mental health policies, programs and activities for employees.
- That the federal government, as an employer, form a partnership with other sectors and jurisdictions, including the Global Business and Economic Roundtable on Addiction and Mental Health, to stimulate and facilitate the exchange of best practices in the support of workplace wellbeing and better employee mental health.
- That, as it develops strategies to support mental health in its workforce, the federal government place a specific emphasis on measures that will reduce and eventually eliminate the stigma attached to mental illness.

It also calls for an evaluation of the federal government's provision of policies, programs and services based on clear performance indicators, and further that the evaluations be used to adjust policies, programs and services to better meet the mental health needs of employees (Recommendation 85).

Recommendation 85

- That the Public Service Human Resources Management Agency conduct annual evaluations of the federal government's provision of policies, programs, and activities designed to support mental health in the public service;
- That these evaluations be based on clear performance indicators that include the use of surveys to assess employee satisfaction;
- That the evaluations be used as a basis for adjustments to policies, programs, and activities in order to better suit them to the needs of employees;
- That results of these evaluations, and the adjustments that were made based upon them, be reported to Parliament on an annual basis starting in 2008.

³⁶ Immigrant, Refugee and Visible Minority Women of Saskatchewan. *Post Traumatic Stress Disorder: The Lived Experience of Immigrant, Refugee and Visible Minority Women*. Winnipeg: Prairie Women's Health Centre of Excellence, 2002.

The mental health of federal employees is important since a healthy workforce will be better able to meet the needs of rural people. One must also recognize that many civil servants are themselves rural residents. There is a need to conduct a gender analysis of the best ways to promote mental health for civil servants.

In each of these areas of federal responsibility - First Nations and Inuit health, Corrections, the Canadian Forces, the RCMP, immigrants and refugees and the federal public service - there are opportunities for specific awareness of the mental health needs of women in rural and remote communities.

Kirby Chapter 14

ABORIGINAL PEOPLES OF CANADA

Aboriginal people have a significant presence in Saskatchewan. Aboriginal residents, including First Nations, Inuit and Métis people, comprised an official estimate of 13.5% of the province's population in 2001. Also half of First Nations people still reside on reserves in rural, remote and northern areas. Many urban residents still retain strong ties to their non-urban communities. Work with Aboriginal people needs to consider geography, variations within cultures, languages and eligibility for federal services.

Kirby recommends establishing an Aboriginal Advisory Committee to the Mental Health Commission comprised of representatives of Aboriginal communities (Recommendation 92).

Recommendation 92

- That the Canadian Mental Health Commission establish an Aboriginal Advisory Committee comprised of representatives of Aboriginal communities, whose membership shall be determined by the Commission in consultation with Aboriginal organizations, and shall provide representation from First Nations, Inuit and Métis and broadly reflect the geographic distribution of Aboriginal communities across the country.

Due to historical Treaty agreements, the Federal government carries responsibility for health care for First Nations and Inuit people -- many living in rural and remote Canada. Métis organizations are stating that Métis people also should have entitlement to similar services. This committee would be responsive to all Aboriginal peoples.

Recommendation 92 includes geographic representation. However, no mention is made of gender equality. Particular attention must be paid to the voices of Aboriginal Women who in the past have been absent or ignored in 'official' consultations. As the Native Women's Association of Canada points out, NWAC supports and adheres to the same principles of engagement as other National Aboriginal Organizations (NAOs), and also believes that applying a culturally relevant gender-based analysis to every process is fundamental to the needs of all Aboriginal women.³⁷ The Native Women's Association of Canada was recently included in the Canadian Aboriginal Peoples' Roundtable and made a case for inclusion of First Nation, Métis, and Inuit women and the use of gender-based analysis in all negotiations. Health was one of the major topics covered by the Roundtable sessions.

³⁷ Native Women's Association of Canada. *Alternative Report*, page 3.

Aboriginal women in Canada face many barriers to full and equal participation in their communities including discrimination based on gendered racism, violence, poverty, single motherhood, disability, low rates of employment and marginalization within their own communities.³⁸ Aboriginal women and their communities are working on positive approaches in creating holistic health, and there is a great opportunity to use their strength and knowledge in improving the factors affecting their health and health services.³⁹

The Mental Health Commission with the Aboriginal Advisory Committee would set goals, a timetable, and an evaluation plan as part of the strategy for mental health wellness and healing among Aboriginal peoples (Recommendation 93). The strategy would identify key health determinants, assess the influence of these determinants on mental health, detail measures for implementation and establish timelines and funding levels to promote wellness and healing (Recommendation 94).

Recommendation 93

- That, as a priority, the Canadian Mental Health Commission, with the full involvement of its Aboriginal advisory committee, develop a strategy for mental health wellness and healing among Aboriginal peoples.
- That the strategy set goals, including a timetable for implementation, and recommend ways to evaluate outcomes.
- That the strategy adopt distinct approaches for First Nations, Inuit and Métis.

Recommendation 94

- That the Canadian Mental Health Commission in consultation with its Aboriginal advisory committee, develop, as an integral component of the wellness and healing strategy for mental health, a plan that would:
 - identify key health determinants;
 - assess the influence of these determinants on mental health;
 - detail measures for implementation; and
 - establish timelines and funding levels needed to promote wellness and healing.

In addition, the Kirby-Keon committee called for an interdepartmental committee of deputy ministers responsible for Aboriginal peoples, to report on the work of their departments and inventory of federal programs and services specific to each group of Aboriginal peoples including, but not limited to, mental health outcomes. Working groups of First Nations, Inuit and Métis representative would provide information, advice and verification of the report (Recommendation 95).

³⁸ Native Women's Association of Canada. *The Native Women's Association of Canada Background Document on Aboriginal Women's Health for the Health Sectoral Session, Following Up to the Canada-Aboriginal Peoples Roundtable*. Ottawa: Native Women's Association of Canada, October 2004, pages 6-7.

³⁹ See Wilson, Alex. *Living Well: Aboriginal Women, Cultural Identity and Wellness*. Winnipeg: Prairie Women's Health Centre of Excellence, 2004. <http://www.pwhce.ca/livingWell.htm>

Recommendation 95

- That the Government of Canada create an interdepartmental committee composed of deputy ministers in departments with responsibility for Aboriginal peoples, chaired by the Privy Council Office.
- That the interdepartmental committee prepare a report to be tabled in Parliament every two years on the impact of the work of these departments on the wellness of Aboriginal peoples, including but not limited to their mental wellness.
- That this Aboriginal wellness report include an inventory of all federal programs and services specific to each group of Aboriginal peoples, with information on spending and the impact on actual health outcomes achieved, including but not limited to mental health outcomes.
- That the interdepartmental committee support working groups composed of First Nations, Inuit and Métis representatives to provide information, advice and verification of the report.

Kirby-Keon states that the Government of Canada, the provinces/territories and the different Aboriginal communities must work together to develop programs and services, enhance community involvement, ensure cultural accommodation and equity of access with appropriate funding and accountability measures (Recommendation 96).

Recommendation 96

- That the Government of Canada work closely with the provinces/territories and representatives from the different Aboriginal communities to develop programs and services deemed necessary by Aboriginal peoples.
- That criteria for the design and delivery of identified programs and services take into account the importance of enhancing community involvement, and of ensuring cultural accommodation and equity of access.
- That any delivery mechanism for these programs and services include ongoing oversight and public evaluation of outcomes by the funding body.
- That the criteria for funding and accountability provisions be made public.

Renewal of the mandate and funding for the federal Aboriginal Healing Foundation for three years would continue its work while evaluating its efficiency and effectiveness (Recommendation 97). (The Foundation supports Aboriginal people in healing to address the legacy of abuse in residential schools.)

Recommendation 97

- That the Government of Canada renew the mandate of the Aboriginal Healing Foundation and provide funding for another three years.
- That, on a priority basis, the Canadian Mental Health Commission and its Aboriginal advisory committee undertake an evaluation of the efficiency and effectiveness of the Aboriginal Healing Foundation.
- That the results of the assessment include recommendations concerning the future of the Aboriginal Healing Foundation and be made public.

Any evaluation of programs should include gender-based analysis to determine if the programs were equally helpful to men and women affected by the residential school experiences and abuses.

Training and employment of Aboriginal persons for careers in mental health is the responsibility of provinces, universities and colleges. The Government of Canada is urged to set targets for Aboriginal health human resources, and increase its social and financial support for Aboriginal students engaged in these studies (Recommendation 98).

Recommendation 98

- That the Government of Canada work with the provinces and with universities and colleges to establish clear targets for Aboriginal health human resources.
- That the Government of Canada finance specific access for Aboriginal students seeking careers in mental health.
- That the Government of Canada increase its financial and social support for Aboriginal students engaged in these studies.

More trained Aboriginal mental health workers will be of great benefit to rural and remote areas.

The mental illness and suicide rates, and alcohol and substance abuse among First Nation, Inuit and Métis peoples call for urgent and effective action in the services directly provided by the Federal government, and to address the root causes of these problems.

A high priority for the Canadian Mental Health Commission would be to identify measures to reduce the alarming suicide rates among Aboriginal peoples. Recommendation 99 also calls for a designated suicide fund to accommodate the distinct needs of each group of Aboriginal peoples and to implement measures identified through research.

Recommendation 99

- That the Canadian Mental Health Commission, as a high priority, identify measures to reduce the alarming suicide rates amongst Aboriginal peoples.
- That identification of these measures be a component of its priority action on an Aboriginal wellness and healing strategy.
- That the Government of Canada allocate a designated suicide fund that accommodates the distinct needs of each group of Aboriginal peoples.
- That the fund include specific allocations for implementing any measures identified by the Canadian Mental Health Commission as well as for increased research by the Canadian Institutes of Health Research and for specific data collection by the Canadian Institute for Health Information in collaboration with the National Aboriginal Health Organization.

As well, the Canadian Mental Health Commission would identify measures to reduce alcohol and substance abuse among Aboriginal peoples (Recommendation 100) with a designated addiction fund.

Recommendation 100

- That the Canadian Mental Health Commission identify measures to reduce the alarming alcohol and substance addiction rates amongst Aboriginal peoples.
- That identification of these measures be a component of its priority action on an Aboriginal wellness and healing strategy.
- That the Government of Canada allocate a designated fund for addiction that accommodates the distinct needs of each group of Aboriginal peoples.
- That the fund include specific allocations for implementing any measures identified by the Canadian Mental Health Commission as well as for increased research by the Canadian Institutes of Health Research and for specific data collection by the Canadian Centre for Substance Abuse in collaboration with the National Aboriginal Health Organization.

The Canadian Mental Health Commission would support research by and for the National Aboriginal Health Organization and the Canadian Institute for Health Information to improved the understanding of mental health causes and outcomes (Recommendation 101).

Recommendation 101

- That the Government of Canada work with the National Aboriginal Health Organization to assess the appropriateness of the First Nations regional health survey for use as a model for data collection for other Aboriginal peoples.
- That the Canadian Institute for Health Information be encouraged to provide analysis of health determinants data related to each of the Aboriginal peoples.
- That the Canadian Mental Health Commission work with the Canadian Institute for Health Information to improve understanding of mental health causes and outcomes.

Kirby-Keon recognized “Alleviating long-term suffering will require long-term funding.” They recommended that the Government of Canada undertake immediate analysis of the current level of funding, assess how much funding would be required to change key health determinants, and develop short, medium and long range plans (Recommendation 102).

Recommendation 102

- That the Government of Canada undertake immediate analyses of the current level of federal funding for Aboriginal peoples. That the analyses assess how much funding would be required to change key health determinants for Aboriginal peoples.

- That the analyses include a short, medium and long range assessment for funding needs.
- That the first report to Parliament by the inter-departmental committee recommended in section 14.6.3 include the results of the analyses.

Gender is a key determinant of health that needs to be considered in this analysis.

Aboriginal women are the caregivers for their families and communities. In addition, they are at particular risk of violence and the poverty and lack of social cohesion often leads to their participation in risky behaviour including the sex trade. Generations raised in residential schools lacked opportunities to experience and learn healthy parenting, homemaking, and self-governance skills. Addressing mental health issues for Aboriginal Peoples also means addressing the issues of today's racism and poverty as well as historical abuse and isolation.

Rural women in Carlyle and Christopher Lake workshops of RWICS talked about the need for more cross-cultural understanding. Although both Aboriginal and non-Aboriginal women have lived in adjacent communities, up to now our lives have been quite separate. However, as women get together to talk about their lives, their concern for their grandchildren, and the communities where they live, they can find common ground and share perspectives that strengthen personal and intercultural understanding.

Kirby Chapter 15

MENTAL HEALTH PROMOTION AND ILLNESS PREVENTION

Mental health should be included as a priority health issue in the Integrated Pan-Canadian Healthy Living Strategy, according to Kirby's Recommendation 103, including development and distribution of a Mental Health Guide (Recommendation 104).

Recommendation 103

- That mental health be included as an immediate priority health issue in the Integrated Pan-Canadian Healthy Living Strategy.

Recommendation 104

- That the Public Health Agency of Canada, in collaboration with other stakeholders, prepare a Mental Health Guide for Canadians and ensure its broad distribution.

Any data collection processes developed under Recommendation 105 must include strategies for conducting gender-place analysis to further awareness and action on issues that have different effects in women than in men, in rural areas than in urban areas, and interactions among gender and place and mental health.

Recommendation 105

- That the federal government commit sufficient resources to enable the Public Health Agency of Canada to take the lead role in identifying national priorities for interventions in the areas of mental health promotion and mental illness prevention and to work, in collaboration with other stakeholders, toward translating these priorities into action.
- That all mental health promotion and mental illness prevention initiatives contain provisions for monitoring and evaluating their impact.
- That the Knowledge Exchange Centre work closely with existing bodies such as the Canadian Institute for Health Information, Statistics Canada and the Canadian Institutes of Health Research to collect and disseminate data on evaluations of mental health promotion and mental illness prevention interventions, including campaigns to prevent suicide.
- That, in this context, the Canadian Mental Health Commission explore the possibility of:
 - developing common measures to evaluate mental health
 - analyzing federal policy initiatives for their probable mental health impact;
 - identifying clusters of problems and/or at-risk populations that are not currently being addressed.

A national suicide prevention strategy is recommended.

Recommendation 106

- That the federal government support the efforts of the Canadian Association for Suicide Prevention and other organizations working to develop a national suicide prevention strategy.
- That the Canadian Mental Health Commission work closely with all stakeholders to, among other things:
 - develop consistent standards and protocols for collecting information on suicide deaths, non-fatal attempts and ideation;
 - increase the study and reporting of risk factors, warning signs and protective factors for individuals, families, communities and society;
 - support the development of a national suicide research agenda along the lines proposed by the Canadian Institutes of Health Research.

Differences in suicide attempts and completion have already been documented for men and women. For example, while more women than men attempt suicide, men are more likely to kill themselves. Gender analysis is basic to suicide prevention and research.⁴⁰

⁴⁰ Donner, Lissa. *Including Gender in Health Planning: A Guide for Regional Health Authorities*. Winnipeg: Prairie Women's Health Centre of Excellence, 2003.
http://www.pwhce.ca/program_gender.htm

Kirby CHAPTER 16

NATIONAL MENTAL HEALTH INITIATIVES

A national mental health strategy must look at the needs of all Canadians and be on the agenda of every level of government and health programming: locally, regionally, provincially, federally and nationally including First Nations, Inuit and Métis representatives.

The Kirby-Keon report recommends a Canadian Mental Health Commission at arm's length from governments and existing mental health stakeholder organizations. The focus would be on people with mental illness and their families. The Commission would be funded to act as a facilitator, enabler and supporter of mental health issues, a catalyst for reform, and an educator.

One of its first actions would be the creation of a Knowledge Exchange Centre. Throughout the report, various tasks for research and distributing information is delegated to the Knowledge Exchange Centre to encourage best practices and to reduce the stigma associated with mental illness.

The Kirby-Keon report also recommends a Mental Health Transition Fund would be available to provinces and territories to initiate and enhance a Basket of Community Services to ensure delivery of mental health services and supports in the community.

Recommendation 9

- That the Government of Canada create a Mental Health Transition Fund to accelerate the transition to a system in which the delivery of mental health services and supports is based predominantly in the community.
- That this Fund be made available to the provinces and territories on a per capita basis, and that the Fund be administered by the Canadian Mental Health Commission that has been agreed to by all Ministers of Health (with the exception of Quebec).
- That the provinces and territories be eligible to receive funding from the Mental Health Transition Fund for projects that:
 - would not otherwise have been funded; that is, projects that represent an increase in provincial or territorial spending on mental health services over and above existing spending on services and supports, plus an increment equal to the percentage annual increase in overall spending on health; and that
 - contribute to the transition toward a system in which the delivery of mental health services and supports is based predominantly in the community.

- That in allocating the resources from the Mental Health Transition Fund priority should be given to people living with serious and persistent mental illness and that a strong focus should be maintained on meeting the mental health needs of children and youth.

New resources would be welcomed to increase awareness and access to mental health resources in all communities. Research, education, and resources offered through the proposed Canadian Mental Health Commission must be scanned through a gender lens to evaluate their particular impact on rural and remote women. Commission members should be oriented to gender/place awareness, and at least two women on the Commission should be asked to maintain this focus in assessing plans, policies, and programs. This gender-place analysis is essential to recognize women who face extra burdens of isolation, distance from services, and the uncertain resource economy as well as the gender issues of poverty, caregiving, violence, and their roles in our diverse culture and society.

The Ad Hoc Committee of the Canadian Women's Health Network and Centres of Excellence for Women's Health further advocates that "the proposed Knowledge Exchange Centre should establish a centre on women and work in close collaboration with existing researchers, organizations and programs" in the areas of women's mental health.⁴¹

Recommendation 10

- That services and supports directed at enabling people living with mental illness to be housed in community settings be eligible for funding as part of the Basket of Community Services component of the Mental Health Transition Fund and administered by the Mental Health Commission.

Recommendation 12

- That a Basket of Community Services that have demonstrated their value in enabling people living with mental illness, in particular those living with serious and persistent illnesses, to live meaningful and productive lives in the community be eligible for funding through the Mental Health Transition Fund.
- That this Basket of Community Services include, but not be limited to, such things as Assertive Community Treatment (ACT) Teams, Crisis Intervention Units and Intensive Case Management programs, and that the only condition for establishing the eligibility of a particular service for funding through the Mental Health Transition Fund be that it be based in the community.

Women, including representatives of remote, rural, Aboriginal, immigrant and disability communities, must be adequately represented on the governing and advisory boards that guide these initiatives.

⁴¹ Ad Hoc Working Group, *Women, Mental Health and Mental Health and Addiction in Canada*, page 8.

Another aspect of the program would be a Mental Health Housing Initiative to increase the availability of adequate, suitable and affordable housing for people with mental illness.

Recommendation 11

- That, as part of the Mental Health Transition Fund, the Government of Canada create a Mental Health Housing Initiative that will provide funds both for the development of new affordable housing units and for rent supplement programs that subsidize people living with mental illness who would otherwise not be able to rent vacant apartments at current market rates,
 - that in managing the housing portion of the Mental Health Transition Fund, the Canadian Mental Health Commission should work closely with the Canada Mortgage and Housing Corporation.

Housing is a major factor for rural and remote women. Overcrowded, inadequate housing is a fact of life for many households in Canada where climate dictates that homelessness means two or more families, or groups of acquaintances, sharing a space designed for fewer people. This is particularly true for many Aboriginal families, both on-reserve and off-reserve. Housing with supervision and support for people with mental health needs is almost non-existent even in urban centres. The Mental Health Transition Fund with its Mental Health Housing Initiative should work with agencies responsible for housing on Reserves to ensure safe and comfortable homes are accessible to First Nation Bands and smaller communities for people with mental illness and limited incomes.

While the Kirby-Keon report speaks of rental housing, thought should be given to enabling home ownership in small communities where this is the norm.

CONCLUSION AND RECOMMENDATIONS

This document has examined the Kirby-Keon report from the perspective of Saskatchewan rural women, with a reference to women living in remote and northern areas, and Aboriginal women.

Kirby and Keon have covered a wide range of issues, many of which are very pertinent to rural women. There are some gaps in the report, the greatest in the Kirby-Keon report is the lack of specific gender analysis. Such an analysis would have led to the stronger identification of family violence, sexual abuse and other abuse as critical factors in addressing and preventing mental health problems for girls and women. Another key point is that women play major roles in the mental health system. The effects of their gender on mental health, service utilization, unpaid care-giving and paid health services work needs to be taken into account.

PRIORITIES FOR WOMEN

The Gender-Place Analysis in this paper revealed several priorities for women living in rural and remote areas in Saskatchewan.

- a. Continue efforts to address the underlying causes of stress and poor health: farm economy, poverty, Aboriginal issues, family violence, balancing work-family-community responsibilities, and the need for inter-generational connections and cross-cultural understanding.
- b. Provide locally-based mental health services to enable people to continue to live well in their home communities, such as local community health workers, peer support groups, respite care and other support for care-givers.
- c. Provide housing with supervision and support for people with mental health needs, enable home ownership in small communities where this is the norm, and improve housing both on and off reserves.
- d. Implement telemental health for psychiatry and psychology services and continue support for the Farm Stress Line and mental health counseling on the HealthLine, balanced with in-person services.
- e. Provide better training for the RCMP in understanding and handling mental health crises.
- f. Orient services to meet the needs of seniors, children and youth, First Nations, Métis and Inuit people.

The federal government has an opportunity to act quickly in those areas in which it has direct responsibility: First Nations and Inuit health, Corrections, the Canadian Forces, veterans, the RCMP, immigrants and refugees and the federal public service.

THE PROCESS

The following are suggested as to guide the process of improving health services and the living situation of women with mental illness living in rural and remote areas in Canada.

1. As a first step, establish and fund the Canadian Mental Health Commission with the mandate to develop a strategic plan with timelines and budgets to implement the recommendations of the Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last*, by Senators Kirby and Keon.
2. Use gender-place-culture lenses in all programs, services, and activities reviewed, initiated and maintained to serve the specific needs of women and men who live in rural, remote and northern communities with respect for the culture, race, and identity of all persons.
3. Evaluate the effect of any policies and services on rural, remote and northern women. Further more detailed work should be done on a gender-place analysis of the Kirby-Keon report and other policy and planning documents.
4. Emphasize the determinants of health approach to address factors affecting health including income, housing, social supports, education and literacy, healthy childrearing, community environments of gender and culture, as well as adequate and appropriate health services. "Health policy is more than health services."⁴²
5. Involve rural, remote and northern women, including Aboriginal women in the planning, management and evaluation of programs that have an impact on their lives, their families, and their mental health including the proposed Canadian Mental Health Commission and Initiatives.
6. Empower and value women in their roles as consumers of mental health services, family and friends of people with mental illness, unpaid caregivers, formal caregivers and professionals in the mental health field, policy makers and management, community and political leaders. In these often overlapping roles, they deserve personal and community support including recognition of their contribution and their right to influence and set policies.

⁴² Sutherns, Rebecca. *Summary Report: Rural, Remote and Northern Women's Health*, page 8.

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