McMaster University | Health Forum

Rapid Evidence Profile

Supporting equitable access to mental health care for rural and remote Veterans and their families

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[MHF product code: REP 86]

Context

- Canadian Veterans experience higher rates of mental health challenges compared to the general population and require different approaches to services that are tailored their unique experiences.
- However, Veterans who live outside of urban centres can face significant challenges accessing the services they need to thrive.
- In this rapid evidence profile, we examine the barriers that Veterans living in rural (population of less than 10,000 people), remote (located over 350 km from nearest service centre with year-round access), or northern communities (north of 60 degrees latitude) experience when accessing mental health and substance-use services, as well as what we know about different approaches that can be used in these communities to expand access to these services.
- In contrast to comprehensive synthesis methods that provide an in-depth understanding of the evidence, this profile focuses on providing an overview and key insights from relevant documents.

Box 1: Evidence and other types of information

+ Global evidence drawn upon

Evidence syntheses selected based on relevance, quality, and recency of search

+ Forms of domestic evidence used (🍁 = Canadian)

Data analytics | Evaluation | Qualitative insights

*** Additional notable features**

Organizing framework was refined based on Veteran feedback

Prepared in five business days using an 'all hands on deck' approach

Questions

1) What challenges are experienced by Veterans and their families living in rural, remote, and northern areas for accessing mental health and substance-use services?
2) What are the features and impacts of approaches to improve access to mental health and substance-use services in rural and remote areas for Veterans and their families?

High-level summary of key findings

- We found 42 highly relevant evidence documents including nine evidence syntheses and 33 single studies.
- Findings from most of the evidence documents were relevant to question one, with many findings noting barriers related in the availability of services in rural, remote, or northern communities, followed by barriers in the approachability of services, acceptability of services, and the appropriateness of services.
- Included documents only covered three of the approaches to improve access to care in rural, remote, and northern communities, with many of the evidence documents describing the use of information communication technologies to overcome barriers in availability.

- Though not included in the approaches section of the organizing framework described below, evidence documents described the use of holistic services such as animal therapies and mind-body therapies, which may be adaptable to rural, remote and northern communities as they require less infrastructure and can complement other mental health and substance-use services.
- With respect to outcomes, included evidence documents identified positive health outcomes and care experiences related to providing and adapting mental health and substance-use services for rural, remote, and northern Veterans, but we found relatively few outcomes related to provider experience and none on affordability.

Framework to organize what we looked for

- Dimensions of access
  - Approachability (e.g., transparency, outreach, information, eligibility)
  - Acceptability (e.g., professional values, norms, culture)
  - Availability and accommodation (e.g., location, accommodation, hours of opening, appointment mechanisms)
  - Affordability (e.g., direct and indirect costs, opportunity costs)
  - Appropriateness (e.g., technical and interpersonal quality, adequacy, coordination and continuity)
- Types of mental health services
  - Mental health and substance-use services
    - Harm reduction services
    - Crisis intervention
    - Psychoeducation for individuals and their families
    - Psychotherapy and other forms of talk therapy
    - Withdrawal management
    - Medication-assisted treatments
    - Peer support
    - Self-help approaches
    - Case management/care coordination
    - Information, referral, and transitional services (including system navigation)
    - Trauma-informed services
    - Culturally relevant services
      - Sharing circles
      - Purification services
      - Sweat lodges

Box 1: Approach and supporting materials

We identified evidence addressing the question by searching Health Systems Evidence and PubMed. All searches were conducted on 7 November 2024. The search strategies used are included in Appendix 1.

We searched for full evidence syntheses (or synthesis-derived products such as overviews of evidence syntheses) and protocols for evidence syntheses.

We appraised the methodological quality of evidence syntheses that were deemed to be highly relevant using the first version of the AMSTAR tool. AMSTAR rates overall quality on a scale of 0 to 11, where 11/11 represents a review of the highest quality, medium-quality evidence syntheses are those with scores between four and seven, and low-quality evidence syntheses are those with scores less than four. The AMSTAR tool was developed to assess reviews focused on clinical interventions, so not all criteria apply to evidence syntheses pertaining to delivery, financial, or governance arrangements within health systems or implementation strategies.

A separate appendix document includes:
1) methodological details (Appendix 1)
2) details about each identified synthesis (Appendix 2)
3) details about each identified single study (Appendix 3).

This rapid evidence profile was prepared in the equivalent of five days of a 'full-court press' by all involved staff.

        - Multi-component interventions using one or more of the above
    - Complementary and alternative therapies
        - Animal-assisted therapies
        - Breathing
        - Meditation
        - Yoga
        - Tai chi
        - Nature-based healing practices
- Mental health or substance-use service setting
    - Community-based care
    - Specialty care
        - Inpatient
        - Outpatient
- Approaches to improve access in rural and remote areas
    - Approaches to reduce stigma in seeking care
    - Issuing rural and remote exceptions to provider scopes of practice
    - Co-locating mental health or substance-use services with other supports
    - Establishing specialist services in regional centres
    - Providing specialist outreach services to areas of need
    - Supporting emergency retrieval services
    - Supporting the use of information communication technologies (e.g., telehealth, virtual care, etc.)
    - Providing peer support to complement mental health and substance-use services
    - Providing transportation and housing supports to access needed care
    - Providing culturally appropriate care
- Outcomes
    - Health outcomes for Veterans, retired RCMP officers, and/or their families
    - Care experience for Veterans, retired RCMP officers, and/or their families
    - Provider experience
    - Cost
- Populations (in addition to those covered in the PROGRESS+ framework)
    - Veterans
        - Veterans who become public safety personnel
    - Family members of Veterans or retired RCMP officers
        - Spouses/partners
        - Children over 18
        - Children under 18
        - Family members outside of the immediate household
    - Retired RCMP officers
        - Special constables
        - Rangers
    - RCMP reservists
    - Canadian Armed Forces reservists
    - Indigenous Veterans
    - 2SLGBTQIA+ Veterans or RCMP officers
    - Racialized Veterans or RCMP officers
    - Francophone Veterans or RCMP officers
    - People with co-occurring substance use
    - People who are homeless or facing precarious housing

What we found

We identified 42 evidence documents, all of which were determined to be highly relevant, including:

- nine evidence syntheses
- 33 single studies.

Coverage by and gaps in existing evidence syntheses and domestic evidence

The included evidence documents address both questions, with 33 (six evidence syntheses and 27 single studies) being relevant to the first question about the barriers that Veterans experience accessing mental health and substance-use services in rural, remote, and northern communities, while eight evidence documents (three evidence syntheses and five single studies) addressed question two about features and impacts of approaches to providing mental health services to Veterans living in rural, remote and northern communities. Twelve evidence documents, including six evidence syntheses and single studies, were relevant to both questions.

With respect to the framework, the majority of the included evidence documents relate to the availability of services (i.e., whether they are present in communities), though evidence documents also covered other dimensions of access including the approachability of services (which included issues related to stigma and privacy in small communities), the acceptability of services, as well as the appropriateness of services. We did not identify any findings related to affordability.

In terms of coverage of the services identified in the framework, many evidence documents addressed mental health services generally, but some included documents specifically addressed crisis intervention, psychotherapy and other forms of talk therapy, multi-component interventions, and complementary and alternative therapies. Most included documents relating to substance-use services addressed access to medication-assisted addictions treatment, notably for opioids and alcohol, but a handful of documents also addressed counselling and treatment and peer/self-help. Included documents covered access to both community-based care as well as specialty care provided in both inpatient and outpatient settings.

Included documents only covered three of the approaches to improve access to care in rural, remote, and northern communities. Among the identified documents, there was a concentration of evidence examining the use of information communication technologies to deliver mental health and substance-use services. Other approaches covered by included evidence documents include:

- co-locating mental health or substance-use services with other supports
- providing culturally appropriate care.

With respect to outcomes, evidence documents reported on health outcomes and care experience, with only one evidence document including outcomes related to provider experience from mental health and substance-use services in rural, remote, and northern communities. We did not identify any cost-related outcomes.

Finally, with respect to specific populations, very few evidence documents addressed the experiences of Veterans' family members. We identified a handful of single studies that also address Veterans with co-occurring substance-use and mental health conditions, Veterans who are facing precarious housing in rural areas, and Indigenous Veterans living in rural communities. We did not identify any evidence documents related to retired RCMP officers or their families.

Key findings from included evidence documents

What challenges are experienced by Veterans and their families living in rural, remote, and northern areas for accessing mental health and substance-use services?

A total of five evidence syntheses and 30 single studies described how Veterans and their families living in rural, remote, and northern regions face significant challenges in accessing mental health and substance-use services.(1-35) Challenges were identified as being multidimensional and impact the continuum of care (e.g., prevention, treatment, rehabilitation) available to Veterans and their families. These challenges include acceptability issues (i.e., stigma and cultural barriers), availability gaps in specialized services and logistical obstacles, approachability concerns (e.g., limited awareness and navigation difficulties), and appropriateness barriers due to technological limitations. No evidence was identified related to any potential affordability challenges that may exist.

Acceptability

Included evidence documents identify some of the acceptability challenges of mental health services in rural communities. Two recent medium-quality evidence syntheses and three recent and five older single studies described how stigma, cultural values, and structural barriers influence the acceptability of mental health services for Veterans in rural areas.(1-10) Issues such as stoicism, self-reliance, and privacy concerns were frequently highlighted, along with additional challenges faced by equity-deserving subpopulations, including women, racial minorities, and 2SLGBTQIA+ individuals.(1-10)

One recent low-quality evidence synthesis and one older single study explored how stigma surrounding mental health and substance-use disorders can prevent Veterans from seeking help. In particular, these documents pointed out issues such as the fear of judgment, cultural values, military culture, and privacy concerns. A recent low-quality evidence synthesis focusing on the barriers and facilitators to accessing trauma-specific teletherapies found that Veterans may be hesitant to disclose their struggles due to concerns about negative perceptions from their community, family, or employers.(11) The same evidence synthesis and one older single study noted that the value placed on self-reliance and stoicism in rural communities has been found to make it difficult for people to seek help.(9; 11) Furthermore, the same older single study found that the emphasis in the military on building strength and resilience (e.g., praising toughness and self-reliance) has been shown to make Veterans reluctant to acknowledge mental health challenges and seek the appropriate care.(9)

Three older single studies examined other dimensions of acceptability, namely how certain Veteran sub=populations (e.g., women, racial minorities, and 2SLGBTQIA+ individuals) face additional barriers to accessing culturally competent care.(5; 7; 8) The single studies revealed challenges such as a lack of specialized services, cultural insensitivity (i.e., unable to understand or connect with Veterans of diverse backgrounds), and service providers' limited awareness of Veterans' cultural values and experiences.(5; 7; 8) The studies described how rural areas often have limited resources tailored to the specific needs of these groups, such as gender-sensitive mental health care for women Veterans or services addressing the experiences of 2SLGBTQIA+ Veterans.(5; 7; 8) In particular, one of the single studies examined U.S. Veteran service officers' perceptions of access to services by equity-deserving Veteran sub=populations and found that a "one size fits all" approach is often used and that there is a lack of familiarity with the unique needs of equity-deserving groups.(5)

Availability and accommodation

Two recent evidence syntheses (one medium-quality and one low-quality) and 12 single studies (seven recent and five older) examined significant gaps in the availability of specialized mental health and substance-use services in rural areas compared to urban centres.(7; 12-24) Geographic, logistical (e.g., travel time and costs), and resource-based (i.e., limited transportation options, harsh weather conditions) barriers were found to limit Veterans' access to care, particularly in addressing transportation and financial challenges.(7; 12-24)

Two recent evidence syntheses (one medium-quality and one low-quality) and four single studies (two recent and two older studies) examined how rural areas often have fewer specialized mental health and substance-use services

compared to urban centres.(11; 12) In particular, the recent low-quality evidence synthesis and one recent single study highlight how this lack of resources results in reduced access to a wide range of mental health and substance-use services, including those for outpatient care, emergency services, as well as broader social services such as those supporting individuals who are homeless or precariously housed.(11; 14) Furthermore, one recent medium-quality evidence synthesis, one recent single study, and two older single studies found that the limited availability of services and resources can cause providers to feel overwhelmed and lack resources to meet Veterans' mental health needs.(12; 15; 18; 23)

One recent low-quality evidence synthesis and one recent and two older single studies examined how distance and transportation pose considerable obstacles for Veterans living in rural and remote areas.(4; 7; 11; 15) Identified evidence documents highlight several barriers including travel time and costs, limited transportation options, and harsh weather conditions as barriers that significantly influence Veterans use of services and supports.(4; 7; 11; 15) One older single study examining the experience of older Alaskan Indigenous Veterans highlighted that they may have to travel extensive distances for specialized care, creating financial challenges and taking time away from work or family commitments.(7) In addition, one recent low-quality evidence synthesis and two older single studies described how limited public transportation in rural areas can make accessing services even more challenging and extreme weather in northern regions can make travel impossible at times, further limiting access to care.(7; 11; 15)

Approachability

Two evidence syntheses (one medium-quality and one low-quality) and seven single studies highlighted the lack of awareness about available mental health and substance-use services among rural Veterans, compounded by insufficient outreach and the complexities of navigating the Veterans Affairs system.(4; 6; 8; 11; 12; 15; 21; 25-27) These factors were found to make it harder for Veterans to access the care they needed (i.e., both to seek and receive appropriate care).

One recent low-quality evidence synthesis and two single studies (one recent and one older) noted how Veterans may lack awareness about available mental health and substance-use services, including treatment options and how to access them.(4; 11; 15) Some of the barriers highlighted in the identified evidence documents include unfamiliarity with services, limited outreach, and complex navigation (4; 11; 15). In particular, one recent single study found Veterans may not know what resources are available in their community, particularly if they have recently relocated to a rural area.(4) One recent low-quality evidence synthesis and one recent single study found outreach efforts to educate Veterans about mental health and substance-use services may be insufficient in rural regions.(4; 11)

Appropriateness

Three evidence syntheses (one recent medium-quality, one older medium-quality, and one recent low-quality) and 12 single studies explored how telemedicine offers promise in bridging mental health and substance-use service gaps in rural areas but highlighted critical limitations to its use.(3; 5; 7; 10-13; 21; 28-35) In particular, technological challenges, lack of digital skills, and racial disparities were common reoccurring issues identified in the evidence documents that affected the appropriateness of using these approaches to care.

Two recent evidence synthesis (one medium-quality and one low-quality) and three single studies (two recent and one older) explored how, while telemedicine offers potential to expand access to mental health and substance-use services in rural areas, technological barriers can limit its effectiveness. Evidence documents noted challenges such as poor internet access (e.g., lack of access to broadband services), limited digital skills, and concerns about privacy and security.(3; 4; 11; 12) One recent low-quality evidence synthesis and one recent single study highlight that many rural communities continue to lack access to high-speed internet, making videoconferencing unreliable or impossible.(11; 21) In addition, one recent medium-quality and one recent low-quality evidence synthesis and two single studies (one recent

and one older) describe how some Veterans may be unfamiliar with using technology for healthcare purposes or may have reservations about sharing sensitive information through virtual platforms.(3; 4; 11; 12)

What are the features and impacts of approaches to improve access to mental health and substance-use services in rural and remote areas for Veterans and their families?

Key findings related to the features and approaches of providing mental health and substance-use services provided in rural and remote areas for Veterans and their families

Eight evidence syntheses and nine single studies addressed approaches to improve access to mental health and substance-use services in rural and remote areas. Approaches covered in the identified literature include:

- co-locating mental health or substance-use services with other supports
- supporting the use of information communication technologies (e.g., telehealth, virtual care)
- providing culturally appropriate care.

One recent single study described adapting buprenorphine program to treat opioid-use disorder in rural areas by redesigning clinical settings including developing new clinical teams including physicians, pharmacists, and other clinical providers.(16) A second recent single study described developing community-based clinics for buprenorphine prescriptions as opposed to using the large medical centres that are available in urban centres for its distribution.(31)

Two older medium-quality evidence syntheses, one recent low-quality evidence synthesis, two recent single studies, and three older single studies found that the use of information communication technologies (e.g., telehealth, virtual care, mobile health) can support those in rural and remote communities to access mental health and substance-use services and that use of such technologies are largely acceptable to Veterans.(3; 8; 11; 12; 27; 36-38) That said, one older medium-quality evidence synthesis described that successful use of video therapy and other information communication technologies requires trained staff, on-site champions, and supports available to Veterans using the service, while a second recent low-quality evidence synthesis noted that many barriers still exist to Veterans using these supports and should be considered when planning for their use.(11; 12)

With respect to providing culturally appropriate care, one older single study described adaptations to mental health care services for Indigenous Veterans living in Alaska. Key suggestions include:

- training on cultural sensitivity and traditional practices
- providing education on past relationships with Indigenous peoples and opportunities to build trust
- embedding Tribal outreach workers that can help to coordinate different services that are locally and federally available.(7)

Similarly, one recent single study identified ways of adapting telemental services for Indigenous Veterans, and suggested the importance of using a collaborative team approach to include culturally congruent services, ensuring it is complemented by occasional in-person interactions and ensuring that historical trauma and mistrust are directly addressed.(39)

Four evidence syntheses (one recent high-quality, two recent medium-quality, and one older medium-quality) describe providing more holistic mental health services that benefit Veterans' mental health including animal therapies and mind-body therapies.(1; 2; 13; 40; 41) While this is not explicitly mentioned in the included syntheses, these may be more adaptable to rural, remote, and northern communities as they do not require as much supportive infrastructure and/or may complement other mental health and substance-use services available in the community. To this effect, one older medium-quality evidence synthesis did note that the portability of these services is a critical advantage of their use for Veterans in rural areas.(13)

Key findings related to the impact of mental health and substance-use services provided in rural and remote areas for Veterans and their families

Health outcomes

A total of eight evidence documents (five evidence syntheses and three single studies) described the effects of mental health services for rural Veteran on mental health symptoms, most commonly symptoms of post-traumatic stress disorder (PTSD), substance use, and suicide.(11; 29; 36-38; 40-42)

Two single studies examined group therapy for rural Veterans. One recent single study comparing the effects of in-person group motivational learning to a treatment control receiving only self-help supports found Veterans participating in the group-learning program experience improved engagement in the program and reduced alcohol consumption.(29) Next, one older single study of three Veterans Affairs treatment programs in the U.S. compared rural adapted intensive referral or standard referral to a mutual-help group and found no statistically significant differences in either group.(42) However, the authors concluded that incorporating rural-specific elements in referral services for mutual help groups may reduce substance use, addiction severity, and symptoms of PTSD among participants.(42)

Five evidence documents explored the use of virtual mental health services. A recent low-quality evidence synthesis reported that virtual trauma-focused therapy including prolonged exposure therapy, cognitive processing therapy, behavioural activation, and therapeutic exposure therapy show similar rates of reducing PTSD symptoms as in-person therapies in military members and Veterans with PTSD.(11) However, the evidence for cognitive behavioural therapy was inconclusive.(11) One older medium-quality evidence synthesis concluded that mobile health interventions were a feasible and effective solution for improving medication adherence and cognitive function for individuals with psychotic disorders.(36) While this review was not specific to rural Veterans, its findings may extend to them. One recent single study reported that psychotherapy in rural Veterans combined with electronic tablets for health management, compared to individuals who did not receive the tablet, improved the use of mental health services, psychotherapy visits, and medication management, and reduced emergency department visits and suicide incidences and behaviours.(37)

Three evidence documents reported that mindfulness therapies reduced post-traumatic symptoms in Veterans. While neither of these evidence syntheses were specific to Veterans living in rural, remote, or northern communities, they explore services that may be more accessible to remote communities as compared to those that require infrastructure or specialty providers. One recent high-quality evidence synthesis of randomized controlled trials examining the efficacy of mindfulness meditation in military members and Veterans identified that mindfulness meditation significantly reduced PTSD symptoms.(40) Similarly, one recent medium-quality evidence synthesis and a recent single study about mind-body therapies, including mindfulness meditation, for Veterans reported significant reductions in military-related PTSD symptoms.(13; 38)

One high quality evidence synthesis examined the use of service dogs for mental health supports reported an association between service dog interventions and symptoms of PTSD.(41)

Care experiences

A total of eight evidence documents (four single studies and four evidence syntheses) reported that mental health service tailored for rural Veterans could improve care experiences.

One older single study concluded that incorporating rural-specific elements in referral services for mutual help groups could improve participation by helping Veterans feel more comfortable with services.(42)

Four evidence documents described the impacts of virtual services on care experiences. One low-quality recent evidence synthesis reported that virtual therapies can improve convenience and accessibility of using mental health

services for Veterans by reducing transportation challenges, as well as feelings of stigma associated with entering a clinic.(11) Moreover, a recent single study exploring the adoption of primary care telemental health services found that Veterans had positive experiences accessing services and providers were generally content with the adoption of tele-health.(38) Two single studies examined care experience from virtual services among Veteran populations. One recent single study identified that personalized implementation of virtual treatments, such as involving relationship building and mutual learning, improved access to mental health services for rural Indigenous Veterans.(39) One older single study exploring the perspectives of women Veterans using telemental health services concluded that it could provide gender-sensitive care by minimizing stigma and hesitancy for women Veterans seeking mental health support.(8)

One recent single study about mind-body therapies for Veterans described positive care experiences, in particular reporting reduced stigma of seeking support.(38)

Finally, three evidence syntheses identified that animal assisted interventions improved well-being among Veterans and their families. One recent medium-quality evidence synthesis concluded that service dogs can improve engagement with treatments and daily activities, resilience, relationship building with family members, and communication.(1) Similar findings were identified in a recent high-quality evidence synthesis exploring the use of service dogs for mental health supports.(41) This review identified an association between service dog interventions and symptoms of PTSD and increases in social quality and relationship facilitation. The third recent medium-quality evidence synthesis explored the use of equine-assisted services for military families and identified widespread effects for the entire family including reduced mental health issues and greater well-being.(2) Additionally, when combined with a social component equine therapy was found to support Veteran families to share experiences with others and form meaningful connections. While all three evidence syntheses generally reported positive outcomes, one of the syntheses did note that for some spouses service dogs could increase caregiving responsibilities.(1)

Provider experiences

One recent low-quality evidence synthesis exploring virtual trauma therapies reported that providers described having opportunities for rapport building and a strong therapeutic relationship.(11)

Costs

Two evidence documents identified that mental health services for rural Veterans can reduce care costs. One low-quality evidence synthesis focused on virtual services reported reduced costs associated with transportation or missed wages at work among Veterans.(11) Similarly, a single study declared that since mind-body therapies can be delivered in group forms, there is a reduced delivery costs compared to conventional PTSD treatments.(42)

Next steps based on the identified evidence

Based on the identified evidence documents, next steps could focus on:

- tailoring existing services in rural, remote, and northern communities to meet the needs of Veterans
- explore approaches to overcome identified barriers for Veterans in accessing mental health and substance-use services beyond supporting the use of information communication technologies
- determining how identified barriers and approaches apply to the context of Canadian Veterans (given many of the identified findings stem from the U.S. context).

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