ATLAS INSTITUTE
FOR VETERANS AND FAMILIES

The art of the possible: Working together across systems to address barriers to mental health care for rural and remote Veterans and Families

Summary report

This resource was prepared by the Atlas Institute for Veterans and Families. The Atlas Institute would like to thank the following individuals for their contributions to this resource. Please note the names listed include only those who have explicitly consented to being acknowledged as a contributor.

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DISCLAIMER

This summary report is an exact capture of participants' feedback from the roundtable event hosted by the Atlas Institute for Veterans and Families. The content reflects the perspectives and experiences shared by attendees, and no modifications or interpretations have been made by the Atlas Institute. This document serves as a record of the discussions that took place. An accompanying ***rapid evidence profile****, developed in collaboration with McMaster Health Forum, will be used alongside this report to inform policy recommendations aimed at improving mental health care for rural and remote Veterans and Families.*

ABOUT THIS REPORT

On October 19, 2024, the Atlas Institute for Veterans and Families hosted a roundtable in Winnipeg, MB to explore barriers to mental health care for rural and remote Veterans and Families and possible solutions to address those barriers. Attendees included service providers, researchers, government policy makers, Veterans and Families with lived experience either working or living in rural and remote communities. For this event, "Veterans" are defined as both former Canadian Armed Forces (CAF) and Royal Canadian Mounted Police (RCMP) members.

The three main objectives of the roundtable were to:

- **Define the problem:** Engage participants to collectively identify key issues and challenges related to equitable access to mental health supports for rural and remote Veterans and their Families
- **Share knowledge:** Facilitate the exchange of information, research and/or best practices related to improving equitable access to mental health supports for rural and remote Veterans and Families
- **Propose solutions:** Collectively identify potential policy levers and solutions to address issues and challenges identified in "defining the problem"

Each objective was explored through two panel periods and three facilitated breakout sessions (**Appendix 1**, **Appendix 2**). The panel included perspectives from CAF and RCMP Veterans, Family members and service providers with experience living and working in rural and remote communities.

This report summarizes all panellist and breakout discussions, while synthesizing the findings across four themes that arose through a preliminary scan of the literature. These themes are: access and availability, integration and coordination, education and training for service providers, and stigma and social perception. The report also includes findings from a post-event survey from invited participants who were unable to attend. Additionally, the Atlas Institute, in collaboration with McMaster Health Forum,

has developed a **rapid evidence profile (REP)**, a structured and rigorous document that provides a high-level overview and quality assessment of current research evidence. Participants shared their input on an interim search framework to help guide the scope of the REP (**Appendix 3**). In this way, the REP, in combination with the summary report, provides an overview of the current mental health landscape for rural and remote Veterans and Families.

DEFINING THE PROBLEM

The first portion of the roundtable focused on defining the problem of rural and remote mental health care for Veterans and their Families. It comprised a panel discussion followed by six facilitated breakout discussions that explored the unique issues Veterans and Families experience in these communities.

ACCESS AND AVAILABILITY

What we heard from participants

LIMITED PROVIDERS AND SERVICES

Accessing mental health services in rural and remote communities poses significant challenges due to the limited availability of providers and resources. A major issue identified is the difficulty in accessing Family doctors, a widespread concern across both urban and rural areas in Canada. One participant noted a recent study that found that one in five Canadians — or approximately 6.5 million people — does not have a Family doctor, and those who do may not have access to providers who understand their specific needs[1]. Participants also indicated that the shortage of Family doctors in rural and remote communities means that care is often inconsistent and the lack of time providers have for patient care results in insufficient attention to individual needs.

Moreover, rural and remote communities often have a smaller pool of treatment options and providers from which to choose. As a result, Veterans and their Families may not have access to care that best suits their needs. Participants noted that when seeking therapy, individuals may have to see multiple providers before finding one with whom they feel comfortable. The limited availability of providers in rural and remote settings compounds the issue, meaning that Veterans and/or Family members may be stuck with one option that may not always be the right fit. As one participant noted, “It’s Betty or nobody. If you and Betty don’t click, then what?” These experiences are also exacerbated by reports of some care providers refusing to take on Veterans as patients, often citing the complexity of their cases.

This highlights how a limited number of providers also means a lack of specialized services. Participants noted that rural and remote areas often do not have providers who specialize in trauma. Even when these services are provincially available, Veterans may need to travel to urban centres, which can be difficult, costly or impossible. When specialized services are available in rural and remote communities, they sometimes need modifications for trauma-related issues. For example, a participant mentioned that some treatments may require exposure to crowds or travel, which may not be feasible in rural and remote settings.

IN-PERSON AND VIRTUAL SERVICES

Participants noted that access to mental health services for rural and remote Veterans and Families presents unique challenges when it comes to both in-person and virtual services. Participants shared concerns with building rapport virtually rather than in person. For example, participants described how face-to-face interactions may allow for better assessment of body language, tone and facial expressions, which can be critical for understanding the full scope of a Veteran or Family member's mental health. However, in rural and remote areas, access to in-person services is often limited due to geographic barriers and lack of local providers. In most instances, community health care centres are typically the only access point.

Virtual appointments have become more common, enabling easier access to care when in-person visits are not feasible. User comfort and familiarity with remote care platforms such as FaceTime and Zoom have increased since the COVID-19 pandemic. However, these technologies come with their own set of challenges:

- **Internet reliability:** Internet service is often unreliable or insufficient in rural and remote areas, with inconsistent coverage, slow speeds and frequent disruptions. As well, infrastructure limitations make it difficult to establish reliable connections. Additionally, weather conditions can further affect connectivity, leading to interrupted sessions.
- **Cost and availability of Internet:** The cost of Internet access can be an additional burden. Internet costs can be excessively high in some northern regions. One participant cited this as being up to $500 per month in Nunavut. An option in these areas is a satellite-enabled Internet service such as Starlink, but this can involve long installation wait times and has substantial costs of its own.
- **Technological proficiency:** Some Veterans and Families may be uncomfortable with or avoid using technology altogether, either due to a lack of familiarity or proficiency, or a preference for in-person interactions. This avoidance can increase social isolation and make it harder to access necessary mental health support.
- **Mental health crises:** Virtual care may not be an ideal solution during a mental health crisis, as the technology may fail during critical moments. In such instances, in-person crisis services are often unavailable in rural and remote areas, potentially leaving Veterans and Families without immediate support.

POPULATION CONSIDERATIONS

The challenges related to access and availability of mental health services for rural and remote Veterans and Families are diverse for various subpopulations. These populations have unique barriers to accessing care, each requiring tailored approaches to support their mental health needs.

Family members of Veterans can be the first to notice changes in behaviour and may be the first to identify mental health challenges. However, they may be unsure of how or where to seek supports or may experience challenges in encouraging their loved one to seek support. Additionally, many Veteran Family members struggle to access mental health services that specifically address their own needs. Family members may experience the same effects of trauma as the service member, particularly in cases of posttraumatic stress disorder (PTSD), which can go untreated until the Veteran receives appropriate care. For example, one participant noted, "As an RCMP Family member, we do not have support… you can be stationed in a community where you are the only one there… there is no support for the Family at all…" Furthermore, the children of Veterans may face unique challenges, especially when seeking mental health care. Often, they need the support of a parent or guardian to travel long distances to access services. These children may also experience a cultural disconnect when receiving care in urban centres, far from the rural or remote environments where they grew up.

Moreover, many First Nations, Inuit and Métis Veterans and Families have historically been and continue to be affected by colonialism and both systemic and targeted racism. This leads to a deep mistrust of mental health systems and impedes access. As well, participants noted how formal health care seldom integrates traditional healing methods and access to these practices is severely restricted. This also includes inadequate cultural training and lack of awareness among service providers to support these communities effectively. Additionally, while some service providers travel into these communities, it is seen as inconsistent. This can lead to Indigenous Veterans and Families living in rural and remote communities receiving fragmented care and incomplete understanding of their situations, which can result in denial or refusal of claims and support.

Participants also noted how members of the 2SLGBTQIA+ community within the Veteran and Family population often experience difficulty accessing appropriate care due to their unique experiences. In addition to general mistrust, 2SLGBTQIA+ Veterans and Families face a lack of gender-affirming care and safe spaces, especially in rural and remote settings. As well, inadequate training among providers to support 2SLGBTQIA+ individuals may amplify existing mental health challenges and reinforce stigma.

Similarly, women Veterans may also face increased difficulty in accessing providers with gender-specific experiences of trauma. For example, one participant noted that women Veterans who have experienced military sexual trauma or intimate partner violence might not find a provider who specializes or has experience serving this population, which could result in ineffective care.

INTEGRATION AND COORDINATION

What we heard from participants

JURISDICTIONAL AND PROVINCIAL LIMITATIONS

Participants described how the integration and coordination of mental health care for Veterans and Families in rural and remote areas face significant barriers due to jurisdictional complexities and the fragmentation of health services across provincial and federal borders. In Canada, jurisdictional limitations such as provincial/territorial licensing restrictions hinder the ability of mental health professionals to support Veterans and Families who are located outside of their province. This can be particularly problematic for Veterans who return to their home provinces at the end of their service, where they must establish care with new providers.

This can create inequities for Veterans and Families when navigating between federal and provincial systems, as health care is administered provincially. For example, participants noted that the availability of operational stress injury (OSI) clinics varies between provinces and their clinic sites are limited in rural and remote areas. This can result in gaps in care for those who live in areas without local access to these specialized facilities. Participants described how this fragmented system of care, in which Veterans and Families must navigate multiple health care jurisdictions, can significantly delay or prevent timely treatment.

COORDINATION BETWEEN SERVICE PROVIDERS

As part of the discussion on integration and coordination, participants talked about how coordination between Family doctors and mental health professionals is often lacking, making it difficult to accurately assess and treat Veteran and Family mental health challenges. For example, a participant noted that the overlap between physical and mental health symptoms could result in misdiagnosis and/or improper treatment. As described earlier, many Veterans and Families face challenges accessing Family doctors, which further complicates the identification and management of mental health conditions that may require specialized care.

POPULATION CONSIDERATIONS

The lack of integration also extends to Families of Veterans, particularly RCMP Veteran Families. Unlike CAF Veteran Families, RCMP Veteran Families do not have dedicated resource centres like the Military Family Resource Centres (MFRCs). This absence of Family support structures like MFRCs leaves RCMP Veterans and their Families without the same level of care and resources. Furthermore, the lack of coordinated support for Families can exacerbate the mental health challenges faced by Veterans, as Family involvement is often essential to effective treatment and recovery.

For Indigenous Veterans and Families, there is often confusion about which treatments are covered by Veterans Affairs Canada (VAC) and which are covered by Indigenous Services Canada (ISC). This lack of clarity around coverage can result in untreated or inadequately managed mental health conditions. As well, participants described how there is a lack of clarity regarding which agency (federal or provincial) is responsible for providing mental health care to Indigenous Veterans and Families, particularly those living on reserve. This uncertainty is seen as further complicating the integration of care and limits the ability of Indigenous Veterans and Families to receive the support they need. In addition, many Indigenous Veterans and Families in rural and remote areas rely on a psychologist who may only visit once a month, meaning they may not receive comprehensive or timely mental health support. Participants expressed concern that the limited access to regular care can lead to misdiagnoses, delayed treatments or even denial of claims and support.

EDUCATION AND TRAINING FOR SERVICE PROVIDERS

What we heard from participants

SPECIALIZATION

The effectiveness of mental health care for rural and remote Veterans and Families can be deeply influenced by the education and training of health care providers. Participants noted how providers often lack specialization in treating posttraumatic stress injuries (PTSIs) and related mental health conditions, particularly in rural and remote environments. Even when specialized care is available, it can be difficult to find professionals who are registered with VAC or who understand the specific needs of Veterans in rural and remote settings.

CULTURAL COMPETENCY

Participants also described how many service providers in rural and remote areas lack a general understanding of CAF and/or RCMP culture, which can pose a major barrier to effective care. Without an awareness of the challenges and experiences specific to CAF and/or RCMP personnel and their Families, providers may struggle to comprehend the nuances of an individual's situation. This lack of "military literacy" among civilian providers can exacerbate the difficulties Veterans and Families face when seeking care, as their experiences may be misinterpreted or undervalued. Additionally, in rural and remote communities, participants expressed a significant concern that the training of many providers does not adequately address the unique realities of rural and remote life, leading to further challenges in delivering effective mental health care.

POPULATION CONSIDERATIONS

Participants also spoke about the significant role that language barriers play in rural and remote settings. It was noted that there is a shortage of service providers willing to offer services in languages other than English, such as French or Inuktitut. This lack of language competence can lead to significant communication breakdowns. For example, one participant noted that Francophone Veterans and Families with a French language preference may choose to speak English with providers, as they often see it as the "language of business." However, as a result their ability to express concerns may be hindered, further complicating their care. Alternatively, they may not have English proficiency at all and are thus unable to obtain services. Access to services in one's preferred language is viewed as not only a matter of comfort, but also of effective treatment, as language plays a critical role in mental health care and understanding.

The discussion among participants also raised concern that there is a significant gap in psychoeducation for Families of Veterans. Family members who lack the necessary knowledge or resources to support their own mental health and to understand their loved one's mental health challenges can impede recovery and well-being. This lack of support for Families can contribute to the overall challenges Families and Veterans face in accessing and benefiting from mental health services.

Another critical issue raised is the lack of Indigenous cultural competency among many service providers. Many service providers do not understand the unique challenges faced by those in rural and remote areas, which further extends to the lack of training to address the distinct experiences and mental health needs of Indigenous Veterans and Families living in these communities. This is seen in part as being due to the Western medical education system that uses a colonial framework, which often offers solutions to mental health challenges that do not align with Indigenous cultures or the lived experiences of Veterans and their Families[i].

[i] It should be noted that in December 2024, VAC announced a partnership with ISC to increase awareness of culturally safe mental wellness services available to Veterans, though feedback related to the partnership and covered services has yet to be received.

STIGMA AND SOCIAL PERCEPTION

What we heard from participants

AWARENESS AND EDUCATION

Participants noted that a significant barrier to mental health support for rural and remote Veterans and Families is the lack of awareness and misinformation about PTSIs and related mental health conditions. Participants perceived a widespread lack of understanding about how common these mental health conditions are among Veterans, which can lead to misconceptions and stigma. Many Veterans and their Families may not know the symptoms of PTSIs and related mental health conditions or that they are often treatable. As well, in rural and remote areas there is a sense of insufficient awareness on the services available to support those dealing with these conditions. Awareness and education for the public and among the CAF and RCMP communities about these conditions is seen as vital to reducing stigma, fostering acceptance and encouraging Veterans and Families to seek help without fear of judgment or career repercussions.

PRIVACY AND CONFIDENTIALITY

Maintaining privacy and confidentiality can be a significant challenge in rural and remote communities, due in part to the close-knit nature of social connections in these small communities, where many community members often known one another. As a result, Veterans or Family members may feel exposed or vulnerable when seeking mental health support. This lack of privacy can deter individuals from seeking care for fear of being recognized or having their challenges discussed in public spaces. For example, confidentiality within pharmacies can be an issue since individuals may know the people standing behind them in line or they may know the pharmacist. This can also extend to accessing other services, with the risk of someone recognizing one's vehicle in the parking lot. Furthermore, accessing care virtually can also be challenging if there is a lack of private settings (e.g. privacy within the home) or secure online environments.

IDENTITY AND PERCEPTION

Participants described how in CAF and RCMP cultures where strength, resilience and operational readiness are highly valued, members may view seeking mental health services as a career-limiting move that may potentially affect promotions, training opportunities or operational deployments. As well, when members acknowledge mental health issues they may face repercussions, such as the ability to carry weapons or perform other duties central to both their function and identity within these organizations. Participants indicated that within their experiences, both CAF and RCMP cultures have traditionally deeply ingrained this stigma, reinforcing the reluctance to seek mental health support. The fear of being "othered," such as being restricted from certain duties or losing status among peers, can be a powerful deterrent to help-seeking. Participants acknowledged that there have been efforts to address

this issue, including some shifts aimed at reducing stigma within the CAF and RCMP. However, it was seen as still woven into Veteran identity, following them post-service and acting as a barrier to accessing mental health resources.

POPULATION CONSIDERATIONS

Trust in the systems that provide care can be a significant issue for marginalized groups, including but not limited to First Nations, Inuit and Métis, 2SLGBTQIA+ and women Veterans. Participants described how Indigenous and 2SLGBTQIA+ Veterans have historically experienced and continue to experience systemic discrimination in health care systems, which can erode trust and deter them from seeking help.

Participants noted that there is also a lack of research into the specific stigma experienced by different populations, such as rural versus urban Veterans, RCMP versus CAF Veterans and the unique needs of Veteran Families. This lack of targeted research makes it difficult to address stigma and provide tailored care to these groups. As well, participants commented that older CAF Veterans and adult children of Veterans may feel overlooked and unsupported in their mental health struggles, which further isolates them from accessing necessary care.

WHERE DO WE GO FROM HERE? EXPLORING PATHS FORWARD FOR POLICY CHANGE

The next portion of the roundtable focused on exploring pathways for policy change to enhance mental health care for Veterans and Families in rural and remote areas. Following a panel discussion, facilitators held six breakout sessions to explore strategies for improving mental health care for Veterans and Families in these communities.

ACCESS AND AVAILABILITY

What we heard from participants

PROVIDERS AND SERVICES

Veterans and Families living in rural and remote communities face significant challenges in accessing mental health care, partly due to lack of service providers, specialists and treatment options. Participants identified the need for more health care professionals, including doctors, nurse practitioners and paraprofessionals, as well as a variety of therapies and treatment modalities in these communities. While recognizing that it can be difficult for service providers to find Veterans and Families in need of support, participants emphasized the need for service providers to visit rural and remote communities more frequently. Mobile outreach units and satellite care sites can help achieve this continuity of care. Funding and incentives would be required for both mobile clinics and providers. For example, providers could be incentivized through student loan forgiveness, rural practice bonuses and/or access to temporary accommodations.

VIRTUAL AND TELEHEALTH CARE

Participants described how virtual and telehealth care options are crucial as they allow flexible access to services. However, this is dependent on reliable Internet to ensure equitable access in rural and remote settings. Participants pointed out the need for technology upgrades within these communities to achieve this level of consistent care. Raising awareness, lobbying telecommunications companies to improve infrastructure and establishing telehealth subsidies for Veterans and Families lacking adequate technology could be valuable approaches to achieving this.

IMPROVED ACCESS AND OPTIONS FOR VAC SERVICES

Improved accessibility to regional VAC regional offices and services (i.e. CAF Transition Centres) was an identified priority among participants. When a Veteran realizes they are ready for help, timely access to services is needed. For example, a participant mentioned that an appointment is required for in-person VAC services, whereas availability of walk-in appointments would improve immediate access. Although VAC and CAF Transition Centres conduct travel to remote locations on rotation, participants commented that these should occur frequently with the same health care professionals to establish continuity of care. As well, Veterans and their Families living in rural and remote settings currently must pay out-of-pocket travel costs when travelling for mental health services. Participants recommended that VAC consider covering these travel expenses for Veterans and their Families.

Another critical aspect identified by participants is the need for greater inclusivity in regard to both interactions with and coverage of VAC services. Participants flagged the importance of having environments that are welcoming to all Veterans and their Families and support culturally appropriate healing practices. For example, participants described how traditional healing methods such as sweat lodges and sacred medicines have demonstrated long-term effectiveness for both Indigenous and non-Indigenous Veterans. This holistic approach of blending traditional and Western medicine could better address the diverse needs of Veterans and Families. In this way, participants expressed that VAC should consider expanding coverage for Indigenous traditional healing practices and medicines[ii].

A further area of improvement identified by participants lies in clarifying VAC's claims processes. It was noted that these procedures can be complex and overwhelming for many Veterans and Families, making it difficult to access the services and supports they need. The Office of the Veterans Ombud has made strides in reviewing and addressing complaints of individual and systemic unfairness in these cases, along with improving understanding of the claims process. However, VAC should work toward simplifying and making the process more transparent. This would empower Veterans to understand their rights and available options, ensuring that they can navigate the system with greater ease and confidence.

ACCESS TO OSI CLINICS

Participants noted that improving access to OSI clinics is also important. Staffing and procedures at OSI clinics must be sufficient to meet demands, as increased wait times are a barrier to care. Participants suggested that OSI clinics could also broaden their services to be more accessible to Class A Reservists and CAF Rangers, and cover both children and adult children of Veterans. Ideally, these clinics should also work toward providing continuous care without requiring new referrals after a set period. If a Veteran has accessed the clinic previously, they should not require another referral later.

[ii] As noted earlier, there is a recently announced partnership between VAC and ISC to increase awareness of existing culturally safe mental wellness services available to Veterans and their Families.

INTEGRATION AND COORDINATION

What we heard from participants

JURISDICTIONAL AND PROVINCIAL LICENSING

Jurisdictional boundaries and provincial issues can create significant barriers to accessing care. Participants described how provincial and territorial policies often hinder Veterans and Families from receiving timely treatment, especially when they reside in rural or remote areas. For example, although Veterans and Families in northern British Columbia are geographically closer to Edmonton than to Vancouver, they lack the ability to access services in Alberta. Participants suggested that revising policies regarding cross-border access to mental health services would allow Veterans and Families to receive care without being constrained by provincial boundaries.

Additionally, some service providers may want to provide care in remote and rural communities but face challenges in licensing transfers and/or having their licensing recognized in other provinces and territories.

Furthermore, in Canada there is no formal screening process of providers to ensure that those who provide care to Veterans and Families have the experience and knowledge necessary to deliver effective care. VAC's approach to screening mental health providers should ensure that providers have specialized knowledge required to treat Veterans and their Families. A participant noted that the creation of a federal licensing or certification program for professionals specializing in trauma-informed care for Veterans and their Families would ensure that they receive the highest level of care, regardless of where they seek treatment.

CONNECTING SERVICE PROVIDERS

The integration and coordination of mental health services for Veterans and Families in rural and remote areas is seen as a significant challenge. Participants identified a pressing need to enhance connections between service providers. This includes fostering collaboration between Family doctors and other mental health professionals such as psychologists, therapists and counsellors to ensure continuity of care. This would also enable a more holistic and integrated approach. Suggested strategies included developing a national registry of clinicians with experience in treating and monitoring PTSIs and related mental health conditions due to military or police service. This could help Veterans and their Families connect with the right professionals regardless of location. Streamlined referral systems are also seen as essential to reducing the delays in accessing specialized care. As well, referrals to community care through integrated models of clinical services with peer support networks could create a more collaborative environment where Veterans and their Families can feel supported on both a professional and personal level.

CONNECTING FAMILIES

Another area of importance identified by participants is the need to strengthen the connection between Veteran Families and their surrounding rural and remote communities. One participant noted that a dedicated Veteran Family network composed of service providers and community members could bridge the gap between Families and mental health care services, ensuring that Families do not have to navigate the system alone. Furthermore, a foundational first step would be introducing policies that ensure Family members are explicitly included in care planning and providing resources to support themselves and Veterans effectively.

LEVERAGING EXISTING COMMUNITY RESOURCES

Coordinating and integrating existing community resources and mental health supports for Veterans and Families in rural and remote communities could improve outcomes. Participants noted that partnerships with community-led organizations could help increase access to mental health services. For example, the Legion branches or Army, Navy & Air Force Veterans in Canada (ANAVETS) units can assist Veterans with practical matters such as VAC claim forms, while leadership organizations such as the Lions Club can help build stronger community ties. These organizations are already trusted community hubs and leveraging their resources could foster greater buy-in from local populations. As well, these organizations can help disseminate information about evidence-based mental health services for Veterans and their Families, which could ensure that those who need help are aware of the resources available to them. Additionally, leveraging the land itself for nature-based wellness therapies or for mental health care can also enhance other treatments. For example, this may look like mental health therapies delivered within nature or nature-based activities that can foster well-being.

EDUCATION AND TRAINING

What we heard from participants

CULTURAL COMPETENCY

Expanding cultural competency training to ensure that health care professionals are equipped with the knowledge and skills needed to serve Veterans and Families effectively is seen as another key priority for improving Veteran and Family mental health care in rural and remote communities. This includes education and training on military and RCMP culture, trauma-informed care and the unique needs of underserved populations, including but not limited to rural and remote residents, women, First Nations, Inuit and Métis and 2SLGBTQIA+ Veterans and Families. To achieve this, participants suggested that practicums in social work education and medical residencies should include more focused education on mental health care specific to Veterans and Veteran Families. This could ensure that new providers are aware of the unique challenges faced by this population while increasing the availability of specialized,

evidence-based services in all communities. Participants expressed that many mental health professionals are currently unaware of the services provided by VAC and the care options available to Veterans and Families.

PEER SUPPORT

Peer support remains a cornerstone of mental health care for Veterans and Families but is less accessible in rural and remote communities. Based on the discussions, increasing access to peer support and the expansion of peer support networks would be necessary to meet the demand for mental health care. Participants also noted that standardized training in psychological first aid and peer support should also be a priority. This would better equip Veterans and Families with the tools they need to provide meaningful support to one another. This can also extend to entire communities, as the tight-knit nature of rural and remote communities can offer an invaluable resource for peer support. These communities foster a deep sense of responsibility to one another, which can be a powerful tool in mental health care. Harnessing this shared responsibility and close connection between community members to enhance peer support networks can provide a strong foundation for mental health care. However, balancing this strength of community with privacy and confidentiality concerns should be taken into consideration.

STIGMA AND SOCIAL PERCEPTION

What we heard from participants

The need to reduce stigma surrounding mental health issues among Veterans and Families remains in both rural and urban communities. In rural and remote communities however, privacy and confidentiality become particularly important when seeking help due to the limited number of providers and familiarity with other community members. While recognizing virtual and telehealth services may remedy parts of these issues, these may have privacy problems of their own. For example, a participant noted that it may be difficult to talk privately on a virtual call in their Family home. For participants, an ideal end state would be to reduce stigma and social perception of help-seeking behaviour among Veterans and Families to a point where stigma is not a barrier to seeking care. In order to achieve this, an important first step would be to increase awareness among Veterans and Families that seeking help is a strength and not a weakness. As well, building supportive networks in rural and remote communities and providing education and training for community members could be key steps in addressing stigma and fostering understanding. In the meantime, participants suggested that using multipurpose buildings (e.g. community centres or recreational centres) for mental health care settings could help facilitate a sense of privacy by making it more difficult to discern the purpose of a visit within rural and remote communities.

WHAT IS MISSING? A RAPID EVIDENCE PROFILE

The roundtable included a portion dedicated to the development of a rapid evidence profile (REP) in collaboration with the McMaster Health Forum. An REP provides an overview and key insights from research identified within the scope. This REP focuses on two research 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?

Roundtable participants were provided with an interim search strategy framework to help determine the scope and organize the findings. Six breakout discussions were held, during which facilitators asked participants to provide feedback on the search strategy (**Appendix 3**). McMaster Health Forum integrated this feedback into the final literature search. **You can find the completed REP here**.

The following is a high-level summary of the findings.

COVERAGE AND GAPS

A total of 42 studies were identified using the search strategy as relevant to the research questions. The majority of the studies focus on the availability of services, whereas other studies discuss issues of approachability, acceptability and appropriateness of service. However, no documents mentioned affordability of service, which is another key aspect of accessibility.

Additionally, most studies mention mental health services in general, but only some focus on specific treatments such as therapy, crisis intervention and medication for addictions.

Moreover, the studies covered only three approaches to improving access to care in rural and remote communities, including:

- Co-locating mental health services with other supports
- Using technology to deliver services
- Providing culturally appropriate care

Furthermore, some studies focused on health outcomes and care experiences, but only one study included service provider experiences. As well, no studies focused on the costs of these services.

Finally, very few studies looked at specific populations, including the experiences of Veteran Families. These studies included Veterans with both mental health and substance use issues, those facing housing problems and Indigenous Veterans. No studies focused on retired RCMP officers or their Families.

KEY FINDINGS

The challenges to accessing mental health and substance use services for Veterans and Families living in rural and remote areas are organized into four categories: acceptability, availability, approachability and appropriateness.

CATEGORY OF INFORMATION	KEY FINDINGS
Acceptability Comfort and willingness to use mental health services for Veterans and Families living in rural and remote communities	• Stigma, cultural values and privacy concerns often prevent Veterans from seeking help. • Additional barriers include a lack of cultural sensitivity and service providers' limited awareness of Veteran cultural values and experiences. • Specific groups (visible minorities, First Nations, Inuit and Métis, 2SLGBTQIA+ and women Veterans) face a lack of cultural sensitivity and understanding from service providers, which add to their challenges.
Availability Feasibility of finding and using mental health services for Veterans and Families living in rural and remote communities	• Rural and remote communities often have fewer specialized mental health and substance use services, including outpatient care and broader social services. • Geographical challenges and travel considerations (time, cost, weather and transportation options) limit access to care for Veterans.
Approachability Awareness of services and the ability to navigate the system for Veterans and Families living in rural and remote communities	• There is a general lack of awareness about available mental health and substance use services for Veterans in these communities. • Insufficient outreach and complexities of navigating systems further add to these issues.
Appropriateness Suitability and relevance of services for Veterans and Families living in rural and remote communities	• Telemedicine may help address mental health and substance use service gaps in these communities, but there are critical limitations. • Limitations include technological barriers, Internet access, lack of digital skills and privacy concerns.

The approaches to improve mental health and substance use services for Veterans and Families living in rural and remote communities include co-locating services, technology and culturally appropriate care.

CATEGORY OF INFORMATION	KEY FINDINGS
Co-locating services Mental health or substance use services sharing a location with other support services	• Redesigning clinical settings and creating new interdisciplinary teams to treat substance use disorders in rural and remote areas may support recovery. • There may be preference for developing community-based clinics for drug prescriptions and other supports, compared to large medical offices in urban centres.
Technology Supporting the use of information communication technologies	• Telehealth, virtual care and mobile health care are acceptable to Veterans and can support access in rural and remote communities. • Communication technologies require trained staff, champions and other supports that need to be considered in implementation.
Culturally appropriate care Providing culturally safe and competent care to Veterans and Families living in rural and remote communities	• Training on cultural sensitivity and traditional practices, providing education on past relationships and embedding outreach to coordinate services for Indigenous Veterans is crucial for effective service.

The features and impacts of mental health and substance use services for Veterans and Families living in rural and remote areas are organized into four categories: health outcomes, care experiences, provider experiences and cost.

CATEGORY OF INFORMATION	KEY FINDINGS
Health outcomes The effects of mental health services for Veterans and Families living in rural and remote communities	• In-person group therapy may be a promising approach to reduce mental health symptoms and substance use (if remote- and rural-specific elements are incorporated). • Virtual mental health services delivering types of exposure and behavioural therapy for treating PTSD may be as effective as in- person therapy. • Mindfulness therapy may be a more accessible therapy for rural and remote Veterans that has been shown to reduce PTSD symptoms.
Care experiences Perception of care, treatment and support among Veterans and Families living in rural and remote communities	• Mental health services tailored for rural and remote Veterans may improve care experiences. • Incorporating rural- and remote-specific elements in referral services for support groups could improve participation and comfort level with treatment. • Virtual services can improve convenience and accessibility by reducing transportation barriers and stigma. • Animal-assisted interventions can improve engagement with treatment, resilience, relationship-building and communication.
Provider experiences Service providers' perceptions of care for Veterans and Families living in rural and remote communities	• Providers delivering virtual trauma therapies may still have opportunities for building rapport.
Cost Affordability of care for Veterans and Families living in rural and remote communities	• Costs associated with travel or missed wages can be reduced with virtual services. • Group-based forms of psychological treatment may also reduce delivery costs in comparison to conventional PTSD treatments.

CONCLUSION AND NEXT STEPS

The roundtable hosted by the Atlas Institute for Veterans and Families brought together a diverse group of stakeholders to address the significant barriers to mental health care faced by rural and remote Veterans and Families. Through collaborative discussions and knowledge-sharing, participants offered their perspectives in identifying critical issues that are hindering care. These included challenges related to geographic isolation, limited providers and resources, lack of cultural competency and stigma.

Participants' ideas for policy solutions focused on increasing accessibility to mental health services, improving coordination between various support systems, enhancing education and training for mental health professionals and reducing stigma surrounding mental health issues.

The insights shared during the roundtable and the findings from the post-event survey, coupled with the rapid evidence profile, provide first steps in a path forward with tangible actions to address these challenges.

There is an opportunity to improve the mental health care landscape for rural and remote Veterans and Families by continuing to work collaboratively across systems, ensuring they receive the support they need and deserve. The roundtable lays the groundwork for further policy development, research and community advocacy, setting the stage for future efforts to create meaningful, systemic change.

APPENDIX 1: MEETING AGENDA – OCTOBER 19, 2024

TIMING	AGENDA ITEM	SPEAKERS
9:30 – 10 a.m.	Arrival, coffee and refreshments	
10 – 10:05 a.m.	Welcome	MaryAnn Notarianni. Deputy CEO and Executive Vice-President, Knowledge Mobilization, Atlas Institute for Veterans and Families
10 – 10:45 a.m.	Elder opening	Elders Floyd and Faylene Sutherland
10:45 – 11 a.m.	Opening remarks	MaryAnn Notarianni. Deputy CEO and Executive Vice-President, Knowledge Mobilization, Atlas Institute for Veterans and Families
11 – 11:15 a.m.	Networking activity	MaryAnn Notarianni. Deputy CEO and Executive Vice-President, Knowledge Mobilization, Atlas Institute for Veterans and Families
11:15 a.m.– 12:10 p.m.	Morning panel Defining the problem: Understanding the experiences of Veterans, Families and service providers	Moderator: MaryAnn Notarianni. Deputy CEO and Executive Vice-President, Knowledge Mobilization, Atlas Institute for Veterans and Families Panellists: • Tanis Giczi, RCMP Veteran Family member • Fred Connor • Dr. Karis Callaway, PhD, C.Psych, Clinical Psychologist for the Ottawa Operational Stress Injury Clinic • Boyd Merrill, S/Sgt (Ret'd), RCMP
12:10 – 12:50 p.m.	LUNCH	

TIMING	AGENDA ITEM	SPEAKERS
12:50 – 1:30 p.m.	Breakout group discussions: Defining the problem	Facilitated table discussions
1:30 – 2:05 p.m.	Reviewing the literature and breakout group discussions: What's missing? A rapid evidence profile	MaryAnn Notarianni. Deputy CEO and Executive Vice-President, Knowledge Mobilization, Atlas Institute for Veterans and Families Facilitated table discussions
2:05 – 2:55 p.m.	Afternoon panel Where do we go from here? Exploring paths forward for policy change	Moderator: MaryAnn Notarianni. Deputy CEO and Executive Vice-President, Knowledge Mobilization, Atlas Institute for Veterans and Families Panellists: • Tanis Giczi, RCMP Veteran Family member • Fred Connor • Dr. Karis Callaway, PhD, C.Psych, Clinical Psychologist for the Ottawa Operational Stress Injury Clinic • Boyd Merrill, S/Sgt (Ret'd), RCMP • Trevor Jenvenne
2:55 – 3:05 p.m.	BREAK	
3:05 – 4 p.m.	Breakout group discussions: Where do we go from here? Exploring paths forward for policy change	Facilitated table discussions
4 – 4:10 p.m.	Concluding remarks	MaryAnn Notarianni. Deputy CEO and Executive Vice-President, Knowledge Mobilization, Atlas Institute for Veterans and Families
4:10 – 4:30 p.m.	Elder closing	Elders Floyd and Faylene Sutherland

APPENDIX 2: FACILITATED BREAKOUT QUESTIONS

DEFINING THE PROBLEM: UNDERSTANDING THE EXPERIENCES OF VETERANS, FAMILIES AND SERVICE PROVIDERS
Reflecting on your own experiences/knowledge, please use the Post-it notes provided to jot down a few examples of additional challenges that come to mind for you when thinking about access to mental health care in rural or remote communities. Alternatively, feel free to expand on any that have been identified by the panellists.
Now that we have identified some additional challenges and barriers, let us talk about them and try to figure out where in the "system" they exist. Where are these issues encountered? Who has the power to change them?
Looking at what we have mapped out, let us consider how these barriers may impact people differently. For example, how would an RCMP Veteran or a CAF Veteran experience this issue differently? Some other groups to consider as you reflect include: • Rural/remote Veterans versus their urban counterparts • Veteran Families • Indigenous Veterans • Women Veterans • 2SLGBTQIA+ Veterans • Francophone Veterans • Reservist Veterans and Families

WHERE DO WE GO FROM HERE? EXPLORING PATHS FORWARD FOR POLICY CHANGE
Reflecting on the panel and your own experiences/knowledge, what ideas resonated with you? What are some other key elements/conditions/policies that you think need to exist to address barriers to care? Alternatively, feel free to expand on any that have been identified by the panellists.
Now that we have identified some key elements, conditions and policies that are required, let's talk about them and identify which barriers they could help address.
Looking at the flip chart, what barriers/challenges from our morning session remain unaddressed? What elements, conditions or policy changes could address these remaining barriers?

WHERE DO WE GO FROM HERE? EXPLORING PATHS FORWARD FOR POLICY CHANGE
Reflecting on the ideas already put forward, let's explore how some of the proposed solutions or ideas may need further consideration to address unique needs. For example, how would an RCMP Veteran or a CAF Veteran experience this issue differently?
Some other groups to consider as you reflect include: • Families • Indigenous Veterans • Women Veterans • 2SLGBTQIA+ Veterans • Francophone Veterans • Reservists • Rangers

WHAT IS MISSING? A RAPID EVIDENCE PROFILE
Across the dimensions from the framework presented, including access, types of mental health service and populations, are there considerations or items that have been missed in the literature search?
From the gaps and coverage identified in the framework, is there misalignment between what is presented and what is actually available in rural and remote Veteran communities?
Focusing on the dimension of outcomes such as health outcomes, care experience and cost, how do we measure these outcomes as successful for rural and remote Veterans?
Shifting to look at the approaches to improve access in rural and remote areas, what other paths forward should be considered that are not covered in this framework?
Reflecting on these thoughts and what we have discussed earlier in the day on identifying the issues, are there any final thoughts on what could be included in the literature search?

APPENDIX 3: RAPID EVIDENCE PROFILE – INTERIM FRAMEWORK FEEDBACK

DIMENSIONS OF ACCESS

- Accessibility in regards to VAC services
  - Specifically for Family members
- Cultural competency of service providers related to:
  - Specific populations (see "**Populations**")
  - Rural and remote communities
  - Cultures within cultures (e.g. Special Forces versus clerks)
- Efficiency of services
- Stigma and self-stigma in seeking services
- Time to access care

TYPES OF MENTAL HEALTH SERVICES

- Animal-assisted therapy
- Coaches/guides/mentors
  - System navigation
- Community services
  - Resilient communities
- Holistic approaches
  - Cultural or spiritual care
  - Culturally relevant services
    - Purification services
    - Sharing circles
    - Sweat lodges
  - Emerging and novel therapies
    - Breathing
    - Meditation
    - Tai chi
    - Yoga
  - Plant, nature and/or land-based healing practices
- Integration of care and stepped care
  - Integration of care across specialties using an interdisciplinary approach

- Mobile services
- Psychoeducation and psychosocial care
- Services addressing domestic and gender-based violence
- Supports for both male and female survivors of military sexual trauma
    - Experiences of hazing among men
    - RCMP sexual trauma
- Services for moral injury
- Services specifically for Families
    - Family psychoeducation
    - Family therapy and couples therapy

MENTAL HEALTH SERVICE SETTINGS

- Type of delivery method
    - Face-to-face
    - Group
    - Internet-based/virtual

APPROACHES TO IMPROVE ACCESS

- Use of peers to support access and maintaining clinical interventions

HEALTH OUTCOMES

- Family well-being measures
- Outcomes on domains of well-being
- Timelines for recovery
- Validated scales
- Veteran well-being measures

POPULATIONS

- 2SLGBTQIA+
- Adult children
- CAF Reservists
- Children of CAF and RCMP members
- Francophone

- Intersectional
- Racialized
- Rangers
- RCMP Reservists
- Special Constables
- Women members of the CAF and RCMP
- Veterans who become public safety personnel

CARE EXPERIENCES

- Satisfaction measurements
- Therapeutic alignment/alliance

APPENDIX 4: REFERENCES

1. Kiran T, Daneshvarfard M, Wang R, Beyer A, Kay J, Breton M, et al. Public experiences and perspectives of primary care in Canada: results from a cross-sectional survey. CMAJ. 2024 May 21;196(19):E646-656.

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