Integrated Study of the Social Determinants of Rural Health: 2005 Interim Report

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Availability

Copies of the Integrated Study of the Social Determinants of Rural Health: 2005 Interim Report were distributed to all study participants. As well, a copy is posted on Greg Halseth's website at (http://web.unbc.ca/geography/faculty/greg).

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Acknowledgments

During the summer of 2005, our research team visited Fort St. John, Mackenzie, Terrace, and Williams Lake to conduct interviews with health and personal service providers. We wish to express our appreciation to all the individuals who took time out of their schedules to participate in our study. The insights provided through these discussions will assist us in developing a better understanding of the social determinants of health in rural and northern communities.

We would like to thank Anne Burrill for her assistance with the interviews in Williams Lake. We would also like to thank Carla Martin for her involvement with the site profiles and interviews in Fort St. John and Terrace. Furthermore, we thank Alisa Thompson from UNBC's Terrace campus and Betty Powers from UNBC's Peace River-Liard Campus for the support they offered to our team.

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1.0 About the Project

All individuals are faced with stressful events and experiences at some point in their lives. The ability to cope successfully with stressful events, such as a job loss or serious illness, depends on a number of factors, including the quality and accessibility of support networks. The purpose of the Integrated Study of the Social Determinants of Rural Health project is to understand the role of informal and formal care networks for individuals and households under stress. In light of the fact that much of what is known about this topic is based on research conducted in larger urban centres, this study focuses on understanding the systems of supports available to residents in smaller communities. In particular, this project seeks to examine the quality of networks supporting health and care in four communities in northern and central British Columbia: Fort St. John, Mackenzie, Terrace, and Williams Lake.

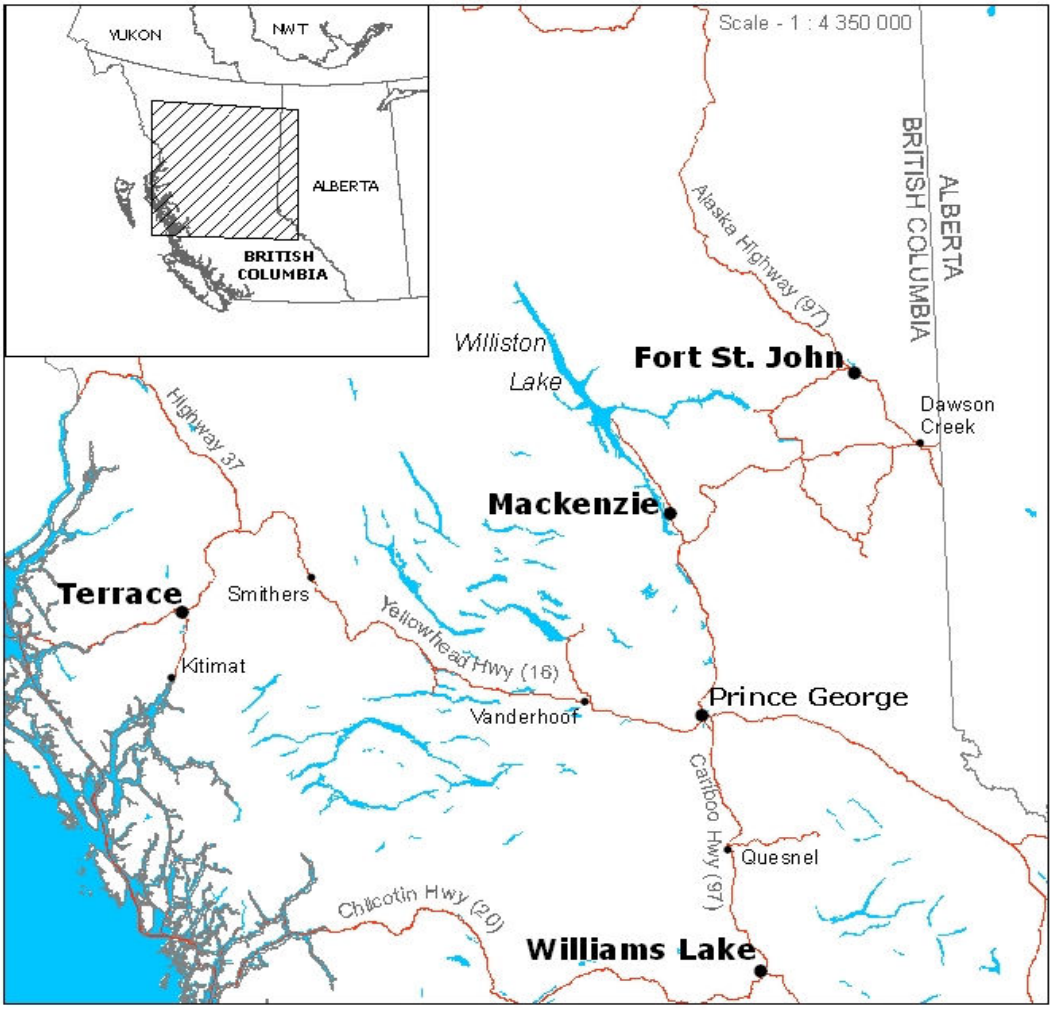
Dependence on a single resource sector has played a central role in community formation in many small Canadian settlements. However, recent trends suggest that rural and northern communities may be less able to withstand market and economic changes compared to urban economies. Economic changes in BC's resource sectors, as well as associated employment reductions and population losses, have an impact on community social fabric and social capital. In turn, these community changes affect the strength of the local informal sector. Furthermore, health care restructuring has affected the formal care sector, resulting in increased interactions with, and dependence upon, informal care sectors. This is the context in which we conduct our study.

This report presents the initial findings from the first stage of a five year study headed by Greg Halseth and Neil Hanlon of the Geography Program at UNBC. It is expected that this research will result in a better understanding of how people cope with stressful life events in smaller communities. Furthermore, it is anticipated that this understanding will contribute to more informed decisions about the roles and responses of governments, volunteers, service providers, neighbours, family, and friends in supporting households under stress.

This research is one component of a larger initiative, the New Emerging Team for Health in Rural and Northern BC headed by Clyde Hertzman and Aleck Ostry of the Department of Health Care and Epidemiology at UBC and funded by the Canadian Institutes of Health Research. The New Emerging Team project aspires to advance knowledge of the social determinants of health and education among children and adolescents, as well as the impacts both of economic dislocation and changes in social capital on the coping ability of rural and northern health and care systems to respond to these changes.

2.0 Site Descriptions and Population Profiles

2.1 Map of Study Sites



2.2 Site Descriptions

2.2a) Fort St. John

Fort St. John is situated in north-eastern British Columbia, approximately 460 km northeast of Prince George and 215 km west of Grand Prairie, Alberta. Completion of the Alaskan Highway in 1942 and the discovery of high-grade oil in 1951 contributed to the growth of Fort St. John. Following the discovery of oil, transportation in the region improved at a rapid rate. The construction of the Hart Highway in 1952 and the arrival of the Pacific Great Eastern Railway in 1958 connected Fort St. John to the rest of the province. Incorporated in 1975, Fort St. John is now the largest city in BC's Peace River region. The city's main industries are oil and gas, agriculture, and forestry. Fort St. John is also a transportation and service hub for the region.

2.2b) Mackenzie

The District of Mackenzie is located in north-central British Columbia, approximately 200 km north of Prince George. The community was established in 1966 near the south end of Williston Lake, a reservoir created by the construction of the WAC Bennett Dam. An "instant town", Mackenzie was developed with capital from British Columbia Forest Products to service large pulp and lumber manufacturing facilities. Since its establishment, economic diversification in Mackenzie has been limited and the forest industry continues to provide nearly all basic sector employment.

2.2c) Terrace

Terrace is located in north-western BC within the Skeena River Valley. It is approximately 575 km west of Prince George and 60 km north of Kitimat. Incorporated in 1927, the town existed as a sawmill community until World War II. Construction of the Alcan smelter in Kitimat in the 1950s contributed to the growth of Terrace by providing jobs during town site and railroad construction. In the late 1950s, highway transportation links between Kitimat and Terrace were constructed. The highway between Hazelton and Terrace was paved in the early 1970s, and in 1971 a bridge was constructed across the Nass River linking Terrace with Meziadin Lake and the Stewart-Cassier Highway. While its economy was historically based on the forest industry, Terrace developed into a hub for highway, rail, and air transportation routes and now serves as the centre for many of the region's business, retail, and government services.

2.2d) Williams Lake

Williams Lake is situated in the Cariboo-Chilcotin region of British Columbia, approximately 550 km north of Vancouver and 240 km south of Prince George. Williams Lake served as a supply depot for ranchers in the 1920s and was incorporated in 1929. The arrival of the Pacific Great Eastern Railway in 1919 spurred early growth in Williams Lake. Growth continued through the 1950s and 1960s with the establishment of several permanent mills in the area. After the opening of the Gibraltar Mine in 1972, Williams Lake became one of the region's fastest growing communities. Although growth has been moderate in recent years, the city has established itself as the principal

service centre in the region, with many residents from outlying towns commuting to Williams Lake for both jobs and services. While primarily based on forestry, the city's economic base includes cattle ranching, mining, tourism, and the service industry.

2.3 Population Profiles

The following table displays demographic information for each study community and British Columbia compiled from Statistics Canada's 2001 Census.

Case Study Communities

Census Data 2001	Fort St. John		Mackenzie		Terrace		Williams Lake		British Columbia	
Population										
Population in 2001	16,034		5,205		19,980		25,122		3,907,738	
Population in 1996	15,021		5,997		20,941		24,992		3,724,500	
1996 to 2001 population change (%)	6.7%		-13.2%		-4.6%		0.5%		4.9%	
Median age of the population	29.6		32.9		34.1		36.5		38.4	
Marital Status										
Total population 15 years and over	12,325		3,925		15,245		19,875		3,201,665	
Single	4,765	38.6%	1,205	30.7%	5,020	32.9%	6,445	32.4%	1,011,280	31.6%
Married	5,550	45.0%	2,220	56.6%	7,645	50.1%	10,110	50.9%	1,626,230	50.8%
Separated	555	4.5%	190	4.8%	725	4.8%	805	4.0%	109,970	3.4%
Divorced	925	7.5%	235	6.0%	1,155	7.6%	1,625	8.2%	260,270	8.1%
Widowed	535	4.3%	70	1.8%	700	4.6%	890	4.5%	193,920	6.1%
Families										
Total number of families	4,235		1,500		5,655		7,280		1,086,030	
Number of lone-parent families	705	16.6%	175	11.7%	985	17.4%	1,215	16.7%	168,420	15.5%
Income										
Median family income ($) - couple/families	$69,830		$76,992		$57,122		$61,465		$54,840	
Median family income ($) - lone-parent families	$25,875		$28,916		$28,228		$26,745		$30,070	
Income from earnings (%)	88.3%		93.0%		81.4%		81.4%		75.8%	
Dwellings										
Total number of private dwellings	6,155		1,850		7,295		9,455		1,534,335	
Number owned	3,535	57.5%	1,485	80.1%	5,250	72.5%	6,840	73.4%	1,017,485	66.5%
Number rented	2,615	42.5%	370	19.9%	1,990	27.5%	2,480	26.6%	512,360	33.5%
Average value of dwellings ($)	$128,224		$96,767		$138,451		$141,229		$230,645	
Unemployment										
Unemployment rate	9.2		7.7		14.5		14.3		8.5	
Unemployment rate - population 15-24 years	12.9		15.2		18.3		21.7		15.8	
Mobility										
Population 5 yrs+ in age	14,670		4,865		18,480		23,340		3,661,945	
Migrants, pop. 5 yrs+, by mobility status 5 yrs ago	4,590	31.3%	810	16.6%	3,120	16.9%	4,515	19.3%	842,605	23.0%

3.0 Methodology

The data for this stage of the project were collected through interviews with local health and personal service providers. Additional information was obtained through compiling site profiles and collecting Census data for the 4 study sites.

3.1 Research Ethics

The UNBC Research Ethics Board assessed and approved the methodology and questions for the service provider interviews. Approval was also sought and obtained from Northern Health in order to interview their employees. Prior to the site visits, interviewees were supplied with an information sheet describing the project, as well as a consent form to sign. Issues concerning confidentiality, anonymity, and potential risks were addressed within these documents.

3.2 Interviews

The research team visited Fort St. John, Mackenzie, Terrace, and Williams Lake in the summer of 2005 to conduct interviews with health and personal service providers in both formal and informal sector organizations. The purpose of these interviews was to gauge understandings of the key issues of change, stress, and evolving local networks of support.

A list of service providers in the 4 study communities was compiled through the use of service directories, phonebooks, Internet research, and suggestions from interviewees. Potential participants were identified and contacted for interviews by telephone. In order to obtain a thorough understanding of the key issues facing each community, participants were selected from a wide spectrum of service sectors, such as health care, child care, seniors, housing, employment, recreation, education, cultural, and advocacy. A total of 88 interviews were conducted in the 4 study communities.

Table 1: Number of Interviews Conducted in Each Community

Community	Number of Interviews
Mackenzie	17
Williams Lake	23
Fort St. John	27
Terrace	21
Total	88

3.3 Interview Content

There were four main components to the interview. The first section addressed background information on the organization and its goals. The questions in the second section related to formal health care delivery in the community. The third section of the interview aimed to assess the organization's relationships with other volunteer organizations and formal care providers. The final section focused on general questions about the community and local service delivery. A copy of the interview script is included in Appendix A.

3.4 Future Stages

The service provider interviews conducted in the summer of 2005 represent the first stage of our multi-strategy approach. Over the course of the 5 year study we will check back with our interview participants in order to track changes and stresses in care networks. The second stage of the project will entail conducting focus groups with a range of service users. We anticipate these focus groups will reveal how changes in care networks are affecting people and whether unmet needs persist outside of the formal care agenda. We intend to repeat these focus groups on a two year cycle beginning in the summer of 2006. In the third stage we will undertake an inventory of formal and informal care providers in the case study communities as an additional means to track changes over the study period.

4.0 Results

This section of the report discusses the preliminary results from this summer's service provider interviews. The first part will provide background information on the service providers we interviewed and the range of services they provide. The second part addresses the changes organizations are experiencing in their ability to deliver services. The focus of the third part is issues surrounding access to services. The subject of financial support constitutes the fourth part. The fifth part examines issues surrounding staff and staff support. A discussion of the community context for service delivery comprises the sixth part. The focus of the final part is evolving networks and partnerships amongst service providers.

The results presented in this report will not include community specific data or commentary. Since the sample sizes in each community were small, the results are presented 'collectively' in order to maintain the confidentiality of our participants.

4.1 Service Providers and Services Background

The interviews covered a broad spectrum of service sectors. Just over half were conducted with individuals from organizations in the health care and mental health sectors. In addition, the interviews addressed the employment, advocacy, child care, seniors, cultural, housing, education, and recreation sectors. Table 2 lists the share of interviews we conducted according to service sector.

Table 2: Interviews by Sector

Sector	Number of Interviews	Percentage
Health Care	27	30.7
Mental Health	20	22.7
Employment	9	10.2
Advocacy	8	9.1
Child care	7	8.0
Seniors	6	6.8
Cultural	4	4.5
Housing	3	3.4
Education	2	2.3
Recreation	2	2.3
Total	88	100

By speaking with service providers from a variety of sectors we were able to obtain a broader understanding of the central issues and concerns of the communities.

Many of the organizations with which we were in contact have a long history of service delivery in their respective communities. As seen in Table 3, almost half of the respondents work for organizations that have provided services for 25 years or more. A small proportion of organizations are newer to the community, having been involved with service delivery for 4 years or less.

Table 3: Years of Service Delivery

Number of Years	Number of Respondents	Percentage
0-4 years	11	2.9
5-9 years	14	16.5
10-14 years	10	11.8
15-19 years	5	5.9
20-24 years	6	7.0
25-29 years	21	24.7
30-34 years	8	9.4
35-39 years	5	5.9
40+ years	5	5.9
Total	85	100

The service providers we interviewed are involved with the delivery of a wide range of services to a variety of clientele. Respondents were asked to describe the types of health and/or personal services their organization provides and Table 4 shows the range of responses that we received. The large number of responses provided by interviewees indicates that many of the agencies offer a variety of services in their community. A notable service sector in this regard is mental health, which includes services for individuals with addictions, serious and persistent mental health disorders, Fetal Alcohol Spectrum Disorder, and brain injuries. As such, the mental health category received the largest number of service type responses. Services specifically for children and youth, such as childhood development programs, youth programs, and at-risk children's services also received a large proportion of the responses. Furthermore, counselling, public health, support group, employment, and home and community care services are provided by a considerable number of our respondents.

Table 4: Types of Health and Personal Services Provided

Type of Service	Number of Respondents	Percentage
Mental Health	39	9.9
Children and Youth	37	9.4
Counseling	34	8.6
Public Health	33	8.4
Support Group	28	7.1
Employment	27	6.9
Home and Community	25	6.3
Housing	23	5.8
Advocacy	21	5.3
Specialized	19	4.8
Primary Health	17	4.3
Referrals	17	4.3
Resource	13	3.3
Other	11	2.8
Sharing Resources	10	2.5
Acute Care	8	2.0
Education	8	2.0
Seniors	6	1.5
Food	5	1.3
Outreach	5	1.3
Cultural	4	1.0
Hospice	4	1.0
Total	394	100

Respondents were also asked to identify the groups of clients to whom they would normally provide their services (Table 5). While a small proportion of respondents offer services to all individuals, the remaining respondents deliver services on a household unit specific, age specific, or topic specific basis. Approximately 30% of respondents stated that they provide services according to a specific age classification. Of these respondents, roughly one third provide services specifically to adults and nearly half offer services for minors, children, and infants. Almost half of the respondents offer their services on a topic specific basis, such as by risk issue, diagnosis, economic group, or cultural group. Of these respondents, around one third provide services specific to a risk issue, such as services for addicts, persons in crisis, or victims of violence. Just over one quarter of these respondents supply services according to a specific diagnosis, such as for patients with cancer, chronic diseases, permanent disabilities, or developmental disabilities. Services for those who are unemployed, underemployed, or low-income are delivered by nearly one fifth of the respondents who cited topic specific service provision.

Table 5: Client Type

Type of Client Serviced	Number of Respondents	Percentage
All Individuals	18	10.2
Age Specific	54	30.5
Household Unit Specific	26	14.7
Topic Specific	79	44.6
Total	177	100

It is evident that our interviews targeted a broad spectrum of services provided by agencies that are generally well established in their respective communities. The experiences of our participants often vary with the type of service they provide and the clientele with whom they work. As a reflection of their experience and diverse backgrounds, respondents were able to provide unique insights and perspectives in response to our questions.

4.2 Changing Service Context

The ability of service providers to deliver services effectively depends on a number of factors, such as current government policy, experience, community dynamics, and access to resources. The context in which service providers operate is continually changing, a circumstance which impacts, in both positive and negative ways, their ability to provide services to those in need. When asked if their ability to deliver services within their community has changed over time, 86% of participants responded 'yes'. Table 6 lists the types of changes respondents have identified.

Table 6: Changes in Ability to Deliver Services

Change	Number of Respondents	Percentage
New approach to delivery	34	26.2
Improved service delivery	21	16.2
Funding decrease	20	15.4
Programs/Services increased	18	13.8
Government changes	10	7.7
Staff cut	7	5.4
Programs/Services cut	6	4.6
Funding increase	5	3.8
Staff increased	3	2.3
Hours cut	2	1.5
Hours increased	2	1.5
Increased demand for services	2	1.5
Total	130	100

A considerable number of respondents identified positive changes in their ability to deliver services. These improvements primarily stem from new approaches to service delivery. In addition, some respondents explained that the knowledge and experience they have gained over time has helped them improve service delivery on a personal level. Other positive changes that respondents mentioned are increased programs, funding, and hours of operation.

Although the majority of respondents cited positive changes in their ability to deliver services, a substantial portion identified negative changes. The most frequently reported negative change was a decrease in funding. Furthermore, cuts to staff, programs, and hours likely stem from decreases in funding. Despite reductions in financial resources, several organizations have developed new adaptations to help them fulfill their mandates. Many agencies have managed to introduce new services and to make improvements to well-established services (Table 7).

Table 7: Changes in Service Delivery

Question	% Yes
Have you noticed an improvement in well-established services?	76.7
Have new services been introduced?	72.7
Have any services been discontinued?	69.9
Is the community aware of the services offered?	93.2

Approximately three quarters of respondents have noticed an improvement in well-established services. The main reason identified for these improvements is increased collaboration. Increased knowledge and experience, increased funding, and accreditation also play a role in improving well-established services. While many respondents stated that new services have been introduced, roughly the same number indicated that services have been discontinued. Mental health, and children and youth services, were those areas where services were commonly discontinued. The services most frequently introduced were in the areas of education and mental health.

Community awareness of available services enables service providers to better assist those in need. Almost all respondents told us that the community is aware of the services that they offer. Community awareness is most commonly achieved through advertising, outreach, networking, and word of mouth. However, some respondents reported that there is room for improvement and that many people are only aware if they are in need of the particular service.

In summary, the context in which organizations deliver health and personal services is changing. Health care restructuring and socio-economic stresses have had a significant impact on the way in which services are delivered in our study communities. While knowledge and experience play an important role in an organization's ability to effectively deliver services, financial resources are also an imperative to success. Most of the negative changes impacting service delivery have been the result of insufficient funding. In spite of this, the majority of organizations have been able to improve existing services, as well as to introduce new programs and services.

4.3 Access to Services

An issue facing many service users in smaller communities is access to services. Due to financial constraints, specialized health and personal services are often difficult to provide in smaller places. Service users are, therefore, often required to travel to larger centres in order to access services. In recent years, a number of health services have been closed, downsized, or regionalized, resulting in an increased necessity for travel. In many parts of the province distances to larger centres can be significant, and travel in the winter months can be challenging, making access to services difficult.

Nearly 86% of respondents provide services to clients from out-of-town. Furthermore, when asked if they have many clients who have to travel out-of-town for services, approximately 80% of respondents said 'yes'. The primary destinations for local clients are Vancouver, Prince George, and Kamloops. Table 8 lists the types of services for which clients are often required to travel. The majority of clients typically travel for medical specialist, mental health, or diagnostic services.

Table 8: Out-of-Town Services

Service	Number of Respondents	Percentage
Medical Specialists	27	26.0
Mental Health	15	14.4
Diagnostics	14	13.5
Detox	11	10.6
Child and Youth	9	8.7
Other	9	8.7
Cancer Treatment	6	5.8
Medical Services	5	4.8
Legal Aid/Advocacy	4	3.8
Prison	2	1.9
Acute Care	2	1.9
Total	104	100

Although access to some services is difficult in smaller communities, efforts are being made in other regards to improve service access for clients. Respondents cited increased hours of operation, increased home visits, and decreased waitlists as some examples of service delivery enhancements. Attempts to improve the physical accessibility of facilities involve changing locations, providing transportation, and ensuring there is handicap accessibility. Through networking, collaboration, and referrals, service providers are improving relationships with one another, which can assist clients in finding the most appropriate services for their needs. Furthermore, new technology is increasingly being explored by some respondents as a means to improve service accessibility and to reduce the need for client travel or relocation. For example,

telemedicine can use video conference technologies to link specialists in larger centres to patients in smaller communities. Telepharmacy involves providing pharmaceutical care to patients at a distance through the use of telecommunications and information technologies. These methods may help improve patient care and allow clients to remain in their community.

In general, access to health and personal services is a challenge facing residents of many smaller communities. At times, clients are required to travel long distances, or relocate, to larger centres in order to receive the care they require. This process can isolate individuals from their community and social networks, thereby creating a source of stress. However, new methods of care, such as telemedicine and telepharmacy, are being explored and could have the potential to help service providers alleviate some of the challenges facing service users.

4.4 Financial Support

Financial resources are essential for any organization to successfully deliver services. Many health and personal service providers rely on government funding in order to operate. However, government policies and priorities are often shifting, which impacts the amount of funding available and how that funding is allocated among various service providers. As shown in Table 9, the main source of funding for the majority of respondents is the Provincial Government. Federal Government funding and support from the organization's own revenue follow as the next most important sources of funding.

Table 9: Main Source of Funding

Source	Number of Respondents	Percentage
Federal Government	34	21.4
Provincial Government	76	47.8
Own Revenue	35	22.0
Other	14	8.8
Total	159	100

Almost half of respondents told us they receive funding from the Provincial Government and approximately one fifth obtain funding through the Federal Government. In addition, a considerable proportion of respondents rely on their own revenue, acquired through fundraising, donations, and tenant rent, to provide services. Other sources of funding include money from foundations and grants, as well as municipal and regional governments. In recent years, a number of respondents reported experiencing a shift in funding sources from mainly government sources to an increasing reliance on private donations and fundraising.

It is evident that many service providers have diverse sources of funding, but when asked if they find the resources are available that allow them to provide the services that are most needed, almost 50% said 'no'. The primary concern of respondents is insufficient financial resources (Table 10). Another noteworthy concern is insufficient labour and volunteer hours. Moreover, staffing concerns are often connected to funding issues. In response to another question regarding staffing resources, 40% of respondents reported that funding shortages are the main reason for staff shortages.

Table 10: Program Delivery Resource Concerns

Concern	Number of Respondents	Percentage
Funding	35	42.2
Labour/Volunteer Hours	18	21.7
Other	12	14.5
Geographic Location	10	12.0
Staff Recruitment	8	9.6
Total	83	100

While a number of organizations appear to be experiencing funding difficulties, it is with women's centres, addictions programs, public health nursing, and mental health services that respondents seem to be the most concerned with adequate funding. The most significant impacts of funding cuts on service delivery include program elimination or restructuring. Conversely, a number of respondents feel that they have adequate funding to deliver their services. Results reveal that those working in child development centres, community health programs, Aboriginal programs, and employment centres feel they are more adequately funded. Although also impacted by funding cuts, these respondents tended to emphasize an increase in partnerships and networks with other agencies as ways to help them maintain service delivery.

Inadequate funding also places limitations on the type, and number, of programs which service providers can deliver. Virtually all respondents identified other services that they would like to provide but are unable. Just under half of respondents cited funding shortages as the main reason for not being able to implement the desired services. In addition, over one quarter of respondents attributed their inability to offer additional services to staffing shortages.

In summary, changes in the allocation of government funds, and overall cuts (absolute and relative) to funding, have impacted most service providers in recent years, some more significantly than others. As a result, some programs have been restructured or eliminated. However, rather then reduce services, some organizations have sought out more diverse sources of funding, such as donations, private sector contracts, and a variety of fundraising opportunities. Partnerships and networks with other agencies have also been pursued by some organizations as a means to maintain service delivery in response to funding constraints.

4.5 Staffing Issues and Support

An organization's staff play an integral role in the delivery of services. Frontline workers are in direct contact with clients and serve as the connection to the community at large. Staff shortages, lack of qualified staff, and high staff turnover can have repercussions on the quality and continuity of care provided by an agency. Over half of the respondents indicated that there are services not available as a result of staff shortages. Respondents told us that staff shortages are mainly a reflection of funding deficiencies (Table 11). Other explanations for staff shortages include recruitment difficulties, geographic location, organizational restructuring, volunteer issues, and spousal relocation.

Table 11: Reasons for Staff Shortages

Reason	Number of Respondents	Percentage
Funding Shortages	27	40.9
Recruitment Difficulties	16	24.2
Geographic Location	8	12.1
Organizational Restructuring	6	9.1
Volunteer Issues	6	9.1
Spousal Relocation	3	4.5
Total	66	100

In addition to funding shortages, a considerable proportion of respondents cited recruitment difficulties as a reason for staff shortages. While most respondents stated that their staff have the training and qualifications needed to deliver the service, they did express some difficulty in finding new qualified staff. One the main challenges to finding qualified staff is geographic location. A number of respondents feel that smaller, more remote, communities are not as attractive to potential staff as are larger centres. Furthermore, respondents feel that there is often little incentive to live in the north. Other respondents mentioned that their difficulties in finding qualified staff stem from applicants being unable to meet the organization's standards. In addition, unattractive hours, wages, and benefits contribute to problems with staff recruitment.

While attracting staff to smaller communities can pose challenges to service providers, preliminary results show that retaining staff is also a concern. Over half of the respondents indicated that they are experiencing difficulties retaining staff. Table 12 reveals the numerous reasons for staff retention difficulties.

Table 12: Challenges for Staff Retention

Reason	Number of Respondents	Percentage
Unattractive Hours/Wages/Benefits	13	29.5
Staff Burn-out	5	11.4
Geographic Location	5	11.4
Other	5	11.4
Spousal Relocation	4	9.1
High Standards	4	9.1
Lifestyle Issues	3	6.8
Volunteer Issues	3	6.8
Funding Shortages	2	4.5
Total	44	100

Difficulties in retaining staff mainly arise from unattractive hours, wages, and benefits, as well as staff burn-out and geographic location. Instances of staff turnover, resulting from low rates of staff retention, can lead to gaps in service delivery. Moreover, remaining staff may be required to take on larger workloads in order to maintain services. Respondents identified cases of staff burn-out, where staff are being overworked and are not provided with adequate levels of support or training to reduce their stress.

An important aspect of staff support is training. Upgrading programs and training enable staff to keep up-to-date with current methods in their field and to improve their quality of service delivery. Although 85% of respondents indicated that training and upgrading programs are offered to staff on a consistent basis, for most organizations, funding is still limited. In some instances, employees must fund their own upgrading. Another hindrance to the provision of consistent training is geographic location. Staff are often required to travel out of their community to access training opportunities, which involves a larger financial investment. However, some organizations are finding alternatives to travel by bringing training into the community and utilizing online or teleconferencing methods for upgrading programs.

In summary, many service providers in smaller communities are facing service delivery challenges as a result of staff shortages and difficulties in recruiting and retaining staff. Lack of sufficient funding plays a significant role in this problem by affecting the number of staff an organization can hire, and the type of wages and benefits they can offer. Geographic location also contributes to these staffing concerns, as respondents feel it is more difficult to attract and retain professionals in smaller, more remote, communities. In spite of these challenges, results reveal that staff, within and among organizations, are working to support one another in order to maintain service delivery and to assist their clients.

4.6 Community Context

The ability of health and care providers to deliver services may be affected by their relationship with the general community, as well as by overall community dynamics. Moreover, a community's ability to cope with stressful events or conditions may also be affected by the quality of relationships and interactions within the community. When respondents were asked if people get along and trust one another in the community, responses were largely positive, although some concerns were identified. The main barriers to cooperation and trust are social issues, such as crime, drugs, racism, and population transience. Differences in income, education, and personality, as well as tensions within the community due to local politics are also thought to contribute to distrust. Despite these concerns, small town dynamics, cooperation, safety, friendliness, and community involvement are emphasized by the vast majority of respondents.

Local involvement can enable residents to establish networks of support within the community. Almost all respondents reported that there have been opportunities for residents to become involved in groups and organizations in the community. Table 13 shows the types of opportunities available to residents.

Table 13: Opportunities for Community Involvement

Type	Number of Respondents	Percentage
Recreation, Sports	20	22.7
Youth	13	14.8
Informal Meeting Groups	12	13.6
Community Events	11	12.5
Seniors	9	10.2
Education/Training	8	9.1
Arts	5	5.7
Support Groups	5	5.7
Cultural Groups	3	3.4
Other	2	2.3
Total	88	100

Recreation opportunities are the most often noted opportunities for community involvement, but individuals can choose to get involved with a range of other activities such as youth initiatives, informal meeting groups, community events, or the arts. Despite the availability of these opportunities for community involvement, some respondents feel a need for more volunteer participation, particularly from youth.

An organization's relationship with the general community may also play a role in its ability to access volunteers and to deliver services. Over 70% of respondents described how their organization has a positive relationship with the community. They indicated

that their organization is well respected and they have the support of both the clients and the community. A smaller proportion of respondents identified having a strained or negative relationship with the community. Misinformation, stigma, and distrust are viewed as the primary contributors to these strained relationships. In addition, emerging challenges resulting from staff turnover and funding cuts are also a source of stress. In spite of these challenges, however, the majority of respondents feel that their relationship with the community has improved over time. Through marketing and public outreach, some organizations are attempting to improve relations and address community concerns. Overall, the majority of respondents feel that their community is a good place to deliver services (Table 14).

Table 14: The Community as a Place to Deliver Services

Response	Number of Respondents	Percentage
Good	123	63.7
Poor/Needs Improvement	25	13.0
Issues/Challenges	22	11.4
Other	17	8.8
Improving	6	3.1
Total	193	100

A large number of respondents emphasized that the community is open, supportive, receptive, and welcoming of services. A smaller proportion identified issues and challenges to service delivery in their community. Geographic issues, such as distance to specialized services and transportation for clients from more remote areas, are prominent concerns. Misinformation also poses a challenge for some service providers. These respondents feel that the community is not well informed about social issues and professional roles, which results in challenges for service delivery. However, efforts are being made by some organizations to provide education in order to improve awareness and understanding.

In general, an open and supportive relationship between an organization and the community can improve ease of service delivery. Organizations can also play a role in developing community cohesion by providing opportunities for residents to get involved and to develop stronger relationships with one another. In a more cohesive community, trust and cooperation may be fostered, which can enable the community to become more resilient in adverse circumstances. One expression of community cohesion is the development of networks and partnerships.

4.7 Networks and Partnerships

When organizations are confronted with similar challenges, support can often be found through the development of networks and partnerships. Rather than compete for limited resources, organizations may be able to discover ways to work together to generate potential solutions for their common concerns. When asked how the services their organization provides fits with other programs and services in the community, respondents suggested that they enhance or compliment each other through collaboration, networking, partnerships, referrals, and the sharing of resources.

The sharing of resources and knowledge is one method organizations employ to enhance service delivery. Over 90% of respondents agreed that organizations in their community share resources and knowledge with one another. Table 15 displays examples of how resources and knowledge are being shared among organizations.

Table 15: Knowledge and Resource Sharing

Examples	Number of Respondents	Percentage
Networking	28	26.2
Interagency Meetings	20	18.7
Open Communication	17	15.9
Training/Workshops	15	14.0
Cooperative	8	7.5
Pamphlets, Books, Videos	7	6.5
Presentations	3	2.8
Fundraising	3	2.8
Advisory Committees	2	1.9
Health Care	2	1.9
Referrals	2	1.9
Total	107	100

The most common means of sharing resources are through networking and interagency meetings. Another method that has proven effective for some respondents is through the creation of a ‘cooperative’. Members of the cooperative share finances and administration, provide peer support to one another, and work together to integrate service delivery. Acting collectively has enabled these organizations to use resources more efficiently and become stronger. Despite many examples of resource and knowledge sharing, a number of respondents indicated that there is still room for improvement. Competition for funding, trust issues, and confidentiality are seen as the main impediments to resource sharing.

Confidentiality and trust issues, in addition to cultural issues and misinformation, can also affect the ability of paid service providers, volunteers, and family networks to work

well together in the community. In spite of these barriers, however, the majority of respondents feel that these networks work well together, especially for community events. This is mainly due to open communication, small town dynamics, and the community's caring and generous nature. Furthermore, unless limited by confidentiality, most organizations make an effort to develop a good relationship with their client's informal networks by providing information, resources, and emotional support.

Partnerships are one expression of the positive interaction between paid service providers and volunteer groups. Over three quarters of respondents identified instances of partnerships with local volunteer groups and almost half of respondents partnered with volunteer groups outside the community. The main reasons for this form of collaboration are financial, such as for fundraising, and the sharing of resources and/or space (Table 16).

Table 16: Reasons for Partnerships

Reason	Number of Respondents	Percentage
Financial	11	29.7
Sharing of Resources/Space	10	27.0
Referrals	6	16.2
Other	5	13.5
Special Events	3	8.1
Training	2	5.4
Total	37	100

In general, respondents indicated that these working relationships are improving with time. Some respondents also reported experiencing an increased dependence on partnerships with volunteer groups in recent years. In addition, more than half of respondents have had to call on local volunteer groups to assist with service delivery. This assistance is mainly with special events, fundraising, advice, and referrals. Although respondents reported some instances of unsuccessful partnerships, nearly all respondents found that working with volunteer groups has been successful for clients and their organization. Table 17 shows that successful partnerships help improve collaboration, resource-sharing, fundraising, and rapport with clients. Partnerships can also help decrease competition for limited financial resources.

Table 17: Results of Successful Partnerships

Example	Number of Respondents	Percentage
Increased Collaboration/Resource-sharing	18	43.9
Fundraising	7	17.1
Improved Rapport with Clients	7	17.1
Other	5	12.2
Increased Advocacy	2	4.9
Reduced Competition	2	4.9
Total	39	100

In summary, the sharing of knowledge and resources is one way organizations experiencing similar challenges can support one another. An atmosphere of cooperation may help foster the development of new ways to cope with changing circumstances. Results reveal that opportunities exist to establish partnerships between paid service providers and volunteer groups as a means to assist with service delivery.

5.0 Conclusion

The focus of this summer's research was to gather baseline data and gain insight into the nature of local services, service groups, and partnerships. We wanted to become aware of the opportunities and constraints service providers are facing in light of health and care service restructuring and conditions of socio-economic stress. In addition, we were interested in learning about coping mechanisms that organizations may be utilizing in order to adapt to a changing service environment.

Although results varied considerably between the four study communities, many ideas and concerns were repeated throughout the majority of interviews. Results reveal that the ability of service providers to deliver services has changed over time, in part due to healthcare restructuring and socio-economic stresses. Many organizations are restricted in their ability to deliver services as a result of insufficient financial resources. Inadequate funding limits the type, and number, of programs that organizations can deliver. In addition, levels of funding also affect the number of staff that organizations can employ and the wages and benefits they can offer to staff. Across all four communities, a number of organizations are experiencing difficulties with staff recruitment and retention. The main reasons for these difficulties are funding shortages, unattractive wages and benefits, and geographic remoteness. However, despite the challenges facing organizations in regards to funding, staffing, and geographic location, respondents identified several factors that help facilitate service delivery in their community. The knowledge and experience gained through years of service delivery have helped organizations cope with emerging challenges. Dedicated staff members and supportive communities have also assisted organizations in meeting program mandates. In addition, a number of organizations are exploring different types of network and partnership arrangements in order to maintain service provision. These arrangements may come in the form of resource sharing, interagency meetings, or collaboration with local volunteer groups, and may have the potential to help service providers manage changing circumstances.

While we are still in the early stages of the project, our preliminary findings provide us with a foundation for subsequent stages of research. The focus of next summer's work will be directed towards service users. We are particularly interested in speaking with those individuals who are recently unemployed, chronically ill or disabled, or are the heads of lone parent households. Specifically, we want to know how individuals have been affected by changes in care networks. Have clients experienced changes to the services they need? Are they excluded from programs due to changes in mandates? Is there a lack of continuum of care as the result of high staff turnover? Do unmet needs persist outside the formal care agenda? The responses to these types of questions will present us with another perspective on the issues we explored with this summer's service provider interviews.

Through sharing these results we hope that service providers will be able to identify common concerns and possibly share methods for coping with these issues. Tracking the

changes that occur in the study communities over the next four years will help to enhance our understanding of the key opportunities and constraints facing service providers and service users, as well as document any new approaches to service delivery. We anticipate that sharing these experiences will contribute to more informed decisions about the roles and responses of networks supporting households under stress.

Appendix A - Interview Script

Integrated Study of the Social Determinants of Rural Health

INTERVIEW SCRIPT

Section A: Background Information Questions

The first section of questions asks about your organization and its goals.

A1. What is the name of your organization?

A2. Does your organization have a long history of service delivery in your community?

A3. How long have you been employed by your organization?

A4. What is your role in the organization?

A5. What is the main source of funding for your organization?

A6. Who sets policy and makes program decisions?

Section B: Formal Health Care and Personal Services

In this section, I would like to ask some questions relating to formal health care delivery in your community

B1. Please describe the types of health care services/personal services your organization provides.

B2. Now, we would like to get some details about these services.

B2a. What is the range of services your organization provides?

B2b. What groups of clients does your organization normally provide services to?

B2c. How does the service your organization provides fit with other programs and services in the community?

B2d. What are the busiest programs your organization offers?

B2e. Which programs and services are most intense?

B3. In delivering your programs, do you find:

B3a. The resources are available that allow you to provide the services community members most needed?

B3b. The hours of business are convenient for service users?

B3c. Do the staff have the training and qualifications needed to deliver the service?

B3d. There are training and upgrading courses offered to the staff on a consistent basis?

B4. Do you have many clients from out of town?

B4a. Do you have many clients who have to travel out of town for services?

B4b. Does your organization help with this travel?

B4c. Do you assist with providing referrals out of town?

B5. Please give examples of what your organization has done, or does, to improve service access for clients.

B6. Are there other services you would like to provide but can't? Why not?

B7. Has your ability to deliver services within your community changed over time?

If **YES**,

B7a. How have these services changed? Please explain.

B7b. Have new services been introduced?

B7c. Have any services been discontinued?

B7d. Have you noticed an improvement in well established services?

B7e. Is the community aware of the services offered?

B8. Are you aware of any services not available due to staff shortage?

If **YES**,

B8a. In your opinion, why are there staff shortages?

B8b. Are there difficulties in finding qualified staff?

B8c. Are there difficulties retaining staff in the area?

B8d. Do you feel that the staff providing these services is consistent?

B8e. Has an instance of staff turnover impacted a service you were required to deliver? Why?

Section C: Social Environment

In this section, I would like to ask questions about your relationship with volunteer organizations and formal care providers.

C1. Does your organization partner with local volunteer groups? Please explain.
If **YES**, go to C1a.

C1a. Has this working relationship changed over time and why?

C2. Does your organization partner with volunteer groups outside the community?
If **YES,** go to C2a.

C2a. Has this working relationship changed over time and why?

C3. As a service provider, have you had to call on these local, volunteer groups to assist with service delivery?

C3a. Were they able to provide the service needed?

C3b. If **NO**, why? Please explain.

C3c. Was the organization easily accessible?

C3d. If **NO**, why? Please explain.

C3e. Are these organizations well known for their community work?

C3f. Is the staff consistent?

C3g. In general, has working with these groups been successful for clients and your organization? Please provide some examples.

C3h. Can you think of any instances where these relationships were not successful? Please describe.

C4. Do you have a good working relationship between your clients and their informal networks (such as close family and friends)? Please explain.

C5. How well informed do you think informal networks are about social issues, compassion, and understanding of professional roles? Please explain.

Section D: Community as a Resource

In this section, I would like to ask general questions about the community and local service delivery.

D1. Do people get along in the community?

D1a. If **NO**, why? Please explain.

D2. Do people trust one another in the community?

D2a. If **NO**, why? Please explain.

D3. Have there been opportunities for residents to become involved in groups and organizations in your communities?

D3a. If **NO**, why? Please explain.

D4. How is your organization's relationship with the general community?

D4a. Has it been good over time?

D4b. Has the relationship improved or worsened over time? How?

D4c. In general, how is the community as a place to deliver services? Please explain.

D5. In general, do you feel that paid service providers, volunteers, and family networks work well together in this community?

D6. Do these organizations share resources and knowledge with one another? Please provide some examples.

D6a. If **NO**, why? Please explain.

Section E: Concluding Questions

E1. Is there anything you would like to add that we haven't already touched on?