Rural or Remote Psychiatric Rehabilitation (rPSR)

Psychiatric rehabilitation has been developed, studied, and implemented primarily if not exclusively in urban settings, where formal and funded services are much more available than in rural and remote communities. This partly explains the well-known urban drift of many people with schizophrenia, resulting in their uprooting themselves from their original rural or remote communities. Such relocations can adversely affect recovery by disconnecting people who have disabling mental illnesses from people they know and love. Alternatively families sometimes move to urban settings with relatives who have mental illness, which may disrupt considerably more people's lives. And some people with longstanding psychiatric disability have no choice (due to financial or other reasons) but to remain in their remote communities, whereas others simply choose to stay. Hence, rural or remote psychiatric rehabilitation (rPSR) would be a valuable addition to the mental health services system.

The community mental health program reported here provides services to six sites located in remote communities in Northern Canada. As clinical director of the program, the first author developed rPSR by means of a network of clinicians (two to three per site), administrative staff, and managers. The rPSR program is supported by academic psychiatrists from Southern Canada, who provide fly-in and telehealth consultations to the program and to local family physicians regarding the program's adult service users. Typically 100 service users per year receive psychiatric consultations from the nonlocal psychiatrists. The program also provides psychotherapies to service users and in-person and distance education to its clinicians, such as phone group supervision by the clinical director.

A particularly important component of the program is the use of telehealth technologies, which offer innovative ways of solving some of the struggles in accessing services from remote or rural communities. Clinical appointments, provision of psychiatric rehabilitation, and delivery of training opportunities to local providers can all be facilitated via secure televideoconferencing. The efficacy of telehealth in facilitating face-to-face services is well documented, particularly in relation to mental health care. Providers can also travel to the remote sites to provide face-to face-services while delivering care back to their originating site by telehealth (flipping the direction of care). Finally, newly developed desktop teleconferencing provides opportunities for direct-to-home or direct-to-agency delivery of care from anyone on the rPSR team.

The implementation of rPSR is conducted by the program's clinicians, who use standard psychiatric rehabilitation interventions. Social skills training enhances social support, which is particularly important in rural and remote communities where selecting one's social support is not as easy as in urban settings. In addition, to accommodate the relative staffing shortage and large geographical distances that are typical of rural and remote communities, some rPSR is provided by task shifting with a train-the trainer-approach. These trainers then reach out to motivate and train interested relatives, friends, and neighbors to provide support and some skills training—such as role modeling of social skills—to the involved service users.

There are various challenges for the program in the provision of rPSR. Offering supported employment is particularly challenging, partly because of the typically high rate of unemployment in the catchment areas of the rPSR sites. Also, access to rPSR education for the program's clinicians has not been easily available in the local settings, due to lack of local psychiatric rehabilitation experts. This challenge was addressed in part by the first author, who is a certified psychiatric rehabilitation practitioner as well as a psychiatrist and who provided formal psychiatric rehabilitation education to the program's clinicians. Sometimes the only available local clinicians have been relatives or friends of people requiring these services, which poses an ethical dilemma concerning whether to transgress boundaries by providing clinical services to a relative or a friend or to abstain from providing this care locally or at all. This challenge has often been addressed by enlisting a clinician from a somewhat nearby site of the program providing this service; this clinician sometimes commuted to the service user's community, and sometimes the service user commuted to the clinician's site.

In spite of such challenges, rPSR is promising as a means to facilitate recovery of people with psychiatric disability in their rural and remote environments of choice. It requires clinical, administrative, and other strategies beyond those of standard psychiatric rehabilitation, such as task shifting and coverage by clinicians across proximal sites. Dedicated funds to conduct research on rPSR would be a highly desirable addition.

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