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Rural Psychiatrists Creating Value for Academic Institutions

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Rural areas comprise 98% of our nation's territory but are typically isolated from larger academic medical centers. Collaborations between rural practitioners and such centers can serve to benefit providers, patients, and academicians. We report on a collaboration that turned an outpatient rural practice into a center providing clinical care, education, and research opportunities for the community and for distant academic medical centers.

Challenges particular to rural psychiatry include patient confidentiality and therapeutic boundary issues, overlapping relationships, cultural and ethical demands, lack of subspecialty support, professional isolation, absence of academic collaboration, and difficulties in recruiting psychiatrists. We describe the highlights of our experience since 1994 at the Sun Valley Behavioral and Research Center in Imperial, California, a rural county where 160,600 mostly Hispanic and Latino people were residing when we launched our clinical and service initiatives.

Among the successful programs is a linked outpatient and consultation liaison service for patients admitted to local general hospitals in a locale where the nearest inpatient unit is 120 miles away. This service has eliminated the need for psychiatric hospitalizations in about two-thirds of consultations. In a community that lacks a dementia unit, we established an adult day treatment center for the elderly population, which helps delay institutionalization. In 2008 we set up a clinical trials division that has collaborated in 38 research projects to date. Since 2011, cooperation between federally qualified health centers and county mental health services has allowed our psychiatrists to train a community clinic team to triage, identify at-risk-patients, follow patients in their homes, and assist with transportation.

Our unsuccessful efforts included a partial hospitalization program that closed when Medicare no longer accepted the host hospital because it was in a different county and an electroconvulsive therapy service that never launched because of perceived stigma and controversy in the community. A National Alliance on Mental Illness chapter and a support group both failed after two sessions because participants were reluctant to disclose private information in this small, tightly interwoven community. Other programs ceased for lack of a large enough base to support group work—again, we believe, a function of the low-density population.

We have learned that rural barriers can be overcome when the services launched are culturally sensitive, scientifically sound, dispensed by competent staff, affordable to the consumer, and have a priori advice from qualified people. Most of our unsuccessful initiatives lacked one or more of these components.

A persistent difficulty is finding capable staff. The likelihood of low practice income and the challenges of a “rural lifestyle” seem to be the main obstacles to recruiting psychiatrists. To address concerns about professional isolation and lack of psychiatrist availability, we created our own supervision program to enhance recruitment of mid-level practitioners such as physician assistants, master’s-level trained therapists, and medical assistants.

Having trained in a large academic center, we have maintained contact with our residency mentor by phone, e-mail, and in person, and we eventually became volunteer faculty at the same university. Collaborating with academicians has helped us understand the importance of publishing as a way of communicating with other psychiatrists, thereby decreasing our isolation, receiving constructive criticism, and stimulating ideas to create new clinical services or improve the existing ones. These collaborations have also resulted in numerous publications focusing on rural psychiatry.

Being liaisons between large academic centers and our rural community has been both challenging and satisfying. The main obstacles to implementing funded research interventions include recruitment, transportation, and attrition. One challenge to recruitment is stigma that is partially overcome with extensive education. A second factor is our low-density population and poor public transportation, such that anyone applying for funds must include a larger-than-usual dedicated travel budget. Even after enrollment, some participants drop out for a variety of reasons, such as family illness, new employment, and time spent applying for benefits, such that flexible schedules for research activities should be considered.

We believe that psychiatric leadership plays an essential role in initiating and implementing these efforts and can help disseminate the idea that rural psychiatry is not only a clinical placement but also an opportunity to perform research and academic activities. Both those already in rural practices and new recruits can be encouraged to collect data, present at meetings, find a mentor, foster online collaborations, and submit to journals. We recommend reaching out to neighboring departments of psychiatry to ignite interest in rural psychiatry and to build academic bridges; we are convinced that rural psychiatrists can create value for academic centers.