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Psychiatric Training in Rural and Remote Areas: Increasing Skills and Building Partnerships

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Rural or remote communities may be ideal locations to train residents in general psychiatry. In addition, evidence from the rural medical education literature suggests that developing educational experiences in these communities may also improve recruitment and retention. University departments of psychiatry, in partnership with national organizations and underserved communities themselves, are beginning to develop training sites in small Canadian communities. This paper examines the

educational opportunities for these sites and explores the necessary adaptation of existing curricula to provide optimal learning in rural and remote environments.

Introduction

Most Canadian provinces have a dramatic imbalance between the number of psychiatrists serving large urban centres and those serving rural and remote communities. Statistics on physician supply in Canada consistently

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reveal ratios as high as 1 psychiatrist for every 30 000 or more people in rural and remote regions (1). This contrasts sharply with ratios as low as 1 psychiatrist for every 5 000 to 12 000 people in the urban regions. Most studies recommend at least 1 psychiatrist for every 8 000 to 10 000 people (2,3).

Until recently, despite long-standing recognition of this problem, academic health sciences centres seemed scarcely interested in addressing the issue. As Dongier noted in 1988, "So far, professional associations have only produced sporadic efforts, and very few academics working in isolation have attempted to establish links with peripheral areas, with various degrees of cooperation and little lasting success" (4, p 338). This is unfortunate because there is ample evidence that some of the main solutions to the problem are under the control of the academic centres. For example, many studies show that physicians are more likely to settle in areas with which they have had a prior personal contact during training (5,6). Curran and Rourke indicate that psychiatry residents who are not born or raised in a rural or underserved area are more likely to practise in a rural area if they received early training exposure to rural practice (6). As well, the literature suggests that training psychiatric residents in rural and remote areas has clear benefits in regard to producing well-rounded general psychiatric graduates.

After defining the parameters of rural, urban, and remote communities, this paper examines the CanMEDS competencies in this context. Next, the paper examines the barriers to developing programs in rural and remote psychiatry. These include the characteristics of rural psychiatrists, the unique demands of rural practice, and resident attitudes to such training. The attitudes of academic programs are examined, as well as their readiness (which includes appropriate supervision and funding) to provide such training. Also examined is the readiness of communities to be partners in the training element of decentralized psychiatry programs. Adjunct training issues such as the use of distance education and other technologies are reviewed. The impact of distributed training networks on recruitment and retention is considered, and the paper concludes with recommendations for practice.

Definitions

Rural communities are variously defined in Canada; no single, commonly accepted definition exists (7). The Organization for Economic Co-operation and Development considers a region to be rural if more than one-half the people live in communities with a population density of fewer than 150 persons per square kilometre (see www.hc-sc.gc.ca). According to that definition, 31.4% of Canadians are estimated to be living in rural or nonurban communities.

It has been noted that rural communities are often dissimilar and that they include a wide range of characteristics. For example, they may be relatively affluent or deprived, agricultural or industrial, stable or mobile, and remote from or proximate to urban areas (8). In Canada, rural communities may have distinctive cultural features derived from historical population settlement, migration patterns, and the rich heritage of Aboriginal communities.

Health care providers, researchers, and government health ministry staff have attempted to construct indices of rurality based on relevant variables such as distance from a referral centre, number of physicians per population, number of specialists per population, and distance from a hospital (7). The Rural Committee of the Canadian Association of Emergency Physicians defines rural remote as "rural communities about 80 to 400 km or about 1 to 4 hours transport in good weather from a major regional hospital" (www.caep.ca/002.policies/002-01.guidelines/recommendations/recommendations.htm; see also 9). The same committee defined communities that are even farther from a major regional hospital as rural isolated.

Whether rural is defined geographically, culturally, by style of practice, or simply by distance from an academic health sciences centre, it is clear that learning in such locations requires a unique and carefully designed set of educational objectives.

Objectives of Training

Many objectives of rural training overlap with those of urban training. However, the nature of rural practice provides a unique opportunity to teach some specific competencies more effectively than is possible in large academic health science centres (AHSCs). This is illustrated if we explore the objectives for training from the perspective of the new CanMEDS roles of the Royal College of Physicians and Surgeons of Canada (RCPSC). In 2000, the RCPSC developed competencies to guide all accreditation and evaluation of postgraduate training in Canada (see http://rcpsc.medical.org/residency/certification/training/psych_e.html#objectives). Not only is this framework mandatory for curriculum design and evaluation, but several of the roles are perhaps better taught in a rural setting. The following considerations arise when the goals of rural education are examined through the lens of the CanMEDS framework.

The Medical Expert as General Psychiatrist

Applied to rural practice, the central CanMEDS role medical expert must be interpreted to mean a broad-based general psychiatrist. Indeed, Goldbloom has argued cogently for the need to create specific training programs for general psychiatrists (10). The highly specialized curricula of large urban schools may not be well suited to

preparing generalist psychiatrists. However, a true general psychiatry curriculum needs careful development and, importantly, specific identification and training for teachers who may not themselves have trained in this way.

Knowledge About and Management of Health Systems

The management skills required for rural practice are not the same as those that are useful in urban practice. In particular, urban-based practice guidelines are not always applicable to very small communities, where working in multidisciplinary teams is essential and where affiliated health care professionals in many cases operate as first-line clinicians for the rural psychiatric service. Rural psychiatrists are involved at many different levels, including community agencies, hospital boards, and mental health and addictions boards. Innovation and creativity are essential to using scarce resources optimally.

A learner in a rural area can directly observe and participate in these elements of the health care delivery system in a way that would be very unlikely in a large urban centre. To avoid inappropriately applying service delivery and education models derived in larger urban centres, educators can create model curricula specific to the health care system of rural areas (11,12).

Communication and Consultation Skills

Many training issues highlighted in the literature on community psychiatry, such as consultation models, outreach programming, crisis intervention, and community organization, are particularly relevant to developing a curriculum for rural psychiatry that emphasizes communication (13). Rural psychiatrists are not in a position to personally treat many of the patients with mental health problems in a community; instead, they rely on a network of service providers. Therefore, specific training in methods of community consultation, such as those classically described by Caplan (14), are important. Good communication skills, and even teaching skills, are important for rural psychiatrists to acquire so that they can help enhance the skills of colleagues from many different disciplines.

Collaboration With Family Medicine and Other Health Professionals Shared—Care Models

A major issue in designing rural educational programs is the psychiatrist's ability to work collaboratively with family physicians. It is clear that rural psychiatrists are often able to assess and follow only the most ill patients in the community. Thus close collaboration with family physicians and other health professionals is essential. Primary care reform across Canada restates the key position of the family physician in the provision of health care and

recognizes family medicine's fundamental role in the delivery of mental health services. This, together with research evidence that family physicians and psychiatrists frequently fail to establish collaborative working relationships, has led to interest in the development of shared mental health care models (15,16). Consequently, methods to teach shared care to psychiatry residents need to be developed.

Continuing Education, Scholarship, and Medical Informatics

Several emerging opportunities in the area of informatics can greatly enhance practice, education, and scholarship in rural settings. Already, many sites are well equipped for such things as video conferencing and high-speed Internet connections. In rural locations, it is necessary to access information and even conduct research via Web searching, to stay in contact with colleagues via listservs, to use on-line professional development and hand-held informatics devices, and to provide and receive consultation and education via video conferencing, which makes such locations ideal places to gain comfort with new technologies.

Health Advocate

It has been suggested that rural communities represent a culture distinct from that of our urban centres. Research is needed into the epidemiology of rural mental health. Locally, psychiatrists may need to take an active role in reducing stigma and improving the mental health literacy of the general population. To take only one example, psychiatrists working in rural and remote areas should develop familiarity with the unique cultures and challenges of Aboriginal communities.

Most people of Aboriginal descent live in urban areas; however, in the northern parts of most provinces and the territories, this group may represent 20% to 95% of the population (www.ainc-inac.gc.ca/gs/dem_e.html). The rural, on-reserve population, in particular, has a well-documented rate of suicide that is 2 to 3 times that of the general Canadian population (17). The Society of Obstetricians and Gynecologists of Canada has developed guidelines for professionals working with Aboriginal People (see www.sogc.org under the link to Guidelines) that could be used as a foundation for curriculum development. Kirmayer has written extensively on the mental health of Aboriginal people in Canada (18) and coordinates a national listserv on the topic that could be accessed by trainees. In addition, a review of resident exposure to Aboriginal health issues in family medicine programs across Canada has documented all programs with relevant curricula, either integrated longitudinally or, in one case, designed as an educational retreat for residents (19). Psychiatry programs perhaps could benefit from sharing these resources with family medicine.

Barriers and Opportunities

Barriers to rural training are frequently discussed in the literature. The primary issue may be that of fostering positive attitudes to the idea of rural curriculum development, both among urban faculty and among residents themselves. Program directors must consider how to ensure adequate educational standards and opportunities at a new site. The realities of geography, particularly in a country the size of Canada, demand heavy investment in travel funding and communication resources to accomplish this. Recruitment and support to sites in the network present an ongoing challenge to a rural training program.

Attitudes

Readiness to provide rural and remote learning experiences will depend on leadership at the highest departmental level and on the attitudes of trainees and faculty members. Understanding trainee interests and concerns will assist the development of postgraduate curricula; it will also direct government efforts to improve practice conditions and recruitment programs.

A lack of respect for rural colleagues on the part of urban faculty is well documented in the rural family practice literature, as is the impact of this attitude on undergraduate career choices (20). The historical lack of collaboration with rural colleagues makes it difficult for universities and rural psychiatrists to trust each other as they trust colleagues at their respective sites.

Convincing residents to leave the resources and urban environment of a training centre remains a challenge, and programs have documented a high anxiety level in urban psychiatry residents who are learning to function in a community environment (21). To address resident concerns about social isolation, some programs attempt to send a group of residents from several disciplines to the same site at the same time.

In one survey that asked 209 Canadian residents about incentives and disincentives to subsequent practice in underserved areas, issues of professional isolation, personal isolation, and the adequacy of services to support psychiatric practice were viewed as more important than remuneration (22). Attitudinal changes are essential if we are to encourage students to consider leaving what they often perceive as the safety of the university during training, let alone to consider becoming rural practitioners once they graduate.

Educational Standards

Formal criteria for assessing the appropriateness of potential teaching sites, which have been established in the rural training streams of some other countries (23), are needed in Canada. Another consideration is whether trainees have the specific skills required to work in rural areas, such as the ability to question and redesign

established methodologies. In rural and remote areas, diagnostic investigations and subspecialty consultation are often not readily accessed, and rural psychiatrists must therefore be comfortable with a greater degree of uncertainty and risk.

Once clear guidelines and objectives for rural training have been established it will be possible, and important, to set standards that can be monitored. These should be established collaboratively, involving both university-based and rural psychiatrists. One way to ensure that standards are maintained is to coordinate and link rural residents with the education activities provided at the AHSCs. In this regard, televideo links are now being used to unify curricula as well as to provide a medium for consultation, supervision, and continuing education (24). However, attempts to integrate rural residents with an AHSC program via televideo link to rounds and teaching seminars are currently found in only a couple of programs in Canada, likely because of the technology's considerable cost. Videotaping lectures or taking advantage of Internet-based audio-visual links may be more economical ways to access tertiary centre expertise. Psychotherapy training is often done longitudinally from PGY2 to PGY5, and some programs use telepsychiatry links for supervision, allowing rural supervisors to monitor the progress of a resident in the city, or vice versa. Nevertheless, distance education requires that many considerations be reviewed, related to cost, quality, and participation (25).

Finally, uniform standards can be encouraged by common programs for faculty appointment, review, development, and promotion; and by opportunities for rural and urban faculty to teach in each others' settings.

Program Resources

A recent survey of all Canadian program directors identified additional barriers to developing training rotations in rural and remote areas (24). In Canada, only 4% of specialists work in rural areas (26). This means that potential preceptors are scarce, and some might have left their academic centre specifically because they were not interested in teaching. Preceptors' appointments within the university will depend on teaching and research expectations.

Another important resource issue is that of call pools. The experience of call is integral to training, and some programs have imposed requirements such as mandatory call participation at rural training sites. In regard to call pools, it is possible that allowing residents to train away from the academic site may place additional strain on remaining residents or faculty. However, it would be a significant deterrent to rural training if residents were obligated to make up for urban call missed during their extended rotations in rural settings. That said, a compromise was

reached in one centre where it was defined that a maximum of 6 months' training time could be spent out of the academic centre call pool but that small community training opportunities were to be made available within driving distance of the AHSC site (A Berntson, unpublished, 2002).

The cost of relocating and accommodating residents at a rural site is a significant deterrent. Housestaff organizations like the Professional Association of Internes and Residents of Ontario and the Professional Association of Residents of British Columbia have stipulated in their most recent contracts that programs with compulsory rotations to rural sites must provide residents with funding for travel and accommodation. Some programs with mandatory rotations have also developed sites that are only a short commute from the teaching centre; these provide a compromise for residents with settled families or a working spouse. Generally, travel support is offered for a defined number of trips per month between the AHSC and the rural or remote site, and accommodations are provided.

Full funding for rural electives is available for most sites in Ontario, either from the communities themselves or from ministry-sponsored medical programs such as the Northwestern Ontario Medical Programme, the North Eastern Medical Program, and the Southwestern Ontario Rural Medicine Unit. The Rural Physician Action Plan in Alberta has a rural initiatives program available to Alberta and Calgary residents; it provides both travel and accommodation support, as well as a preceptor stipend. British Columbia offers residents partial funding for rural electives, and some communities have available accommodation. Dalhousie University offers each psychiatry resident a significant stipend each year for educational enrichment, but it cannot be applied to accommodation. Individual residents may also apply for rural elective or research bursaries offered by some universities, professional, and housestaff organizations.

The Washington, Wyoming, Alaska, Montana, and Idaho program in the US employs economies of scale by organizing a 3-year family medicine curriculum that is applied to training sites in 5 "frontier" states. Central administration keeps costs down while maximizing the resources available to all sites. Residents train centrally for their first year and then are disseminated to community sites for the remaining years (27). Some similar national coordination of rural resources might alleviate obstacles for individual programs in Canada. Ontario's Psychiatric Outreach Program has taken this approach on a province-wide basis.

Network Support

Preceptor stipends are essential to recruiting and maintaining a rural teaching network. Issues pertaining to

remuneration need to be addressed, with changes made to sessional payment coverage or schedules added for fee-for-service practice. Continuing professional development that specifically meets the needs of preceptors must be developed and made available through diverse means.

Common to many successful programs in the literature are education retreats for the combined faculty. The use of telepsychiatry services for consultation, discharge planning, and transfer of care in either direction will also develop closer relationships.

One other area attracting attention in the primary care literature is that of medical informatics support systems for rural preceptors and trainees (28–31). In some cases, these have arisen from medical informatics courses at the academic centre and may be used to coordinate rural curricula, research, or continuing education initiatives. They highlight the need to incorporate medical librarians into rural curriculum development strategies and to use innovations like Loansome Doc Ordering System, a document delivery service for rural health care professionals in the US. McMaster University and the Northern Academic Health Sciences Network in Ontario recently announced the advancement of the Digital Health Library (DHL) for 40 northern sites. The DHL is a network for northern health professionals to access clinical resources specific to their areas of interest (32).

Rural Research

The Canadian Institutes for Health Research recently requested applications for an initiative entitled Building Healthy Communities Through Rural and Northern Health Research. Academic interests can now maximize a distributed learning network for large-scale studies incorporating both rural and urban cohorts. Patient-encounter databases are being initiated for rural and remote training sites, and the information they provide will help inform both rural public health initiatives and curriculum development.

Yellowlees, practising in a small mining community in New South Wales, Australia, has reported on a unique innovation: the employment of a full-time research officer in a small community setting (33). The added dimension of participating in research would likely be attractive to academically minded trainees and faculty who might otherwise avoid rural practice environments. As well, time made available for research might just as readily be devoted to a rural project as to an urban one, increasing the total time spent in a rural area through the course of training.

Models for Training Experiences

Currently, the type of rural and remote opportunities available to Canadian psychiatry residents vary widely.

In the Maritimes, and in some Quebec programs, small community training sites have been used for years. Most other programs have no mandated time in these settings, and trainee interest tends to be low. Where this is the case, opportunities often depend on the outreach activities of individual preceptors. Ontario has recently developed a more structured outreach program and is also developing core rotations in small northern referral centres.

Rural and remote curriculum models address 1 of 2 mandates. Either urban-based consultants train residents to emulate a rurally sensitive outreach consultation model or trainees are integrated into a local community agency or treatment team. Long-term relationships can develop in either model.

Brief electives with urban-based preceptors have the advantage of requiring a low level of commitment from the trainee. They can be a good first exposure, and may pique interest in longer rotations. In some cases preceptors will request that residents attend the outreach clinic numerous times to follow patients and develop a relationship with the local treatment team. Indeed, these residents may be the only source of psychiatric service available to very small communities. In larger communities, visiting specialist clinics may supplement local psychiatric services. However, there may be little contact with local practitioners and no exposure to their full practice pattern or lifestyle.

As electives, fly-in or drive-in clinics can be quite resource-intensive relative to the actual experience gained. Airfare, accommodation, and ground transportation costs are considerable, although they are sometimes covered by provincial programs. If made a mandatory part of training, residents' costs must be covered, according to provincial housestaff contracts that have addressed this issue.

On-site training can be constructed either as a block rotation of 1 to 6 months or as a longitudinal elective, in nearby communities, of 1 to 2 days weekly over 6 to 12 months. Preceptors are local psychiatrists who can model a rural or remote career. Postgraduate training streams based outside the academic centres are developing, but they still depend on urban medical schools for administrative support and subspecialty expertise. Northern medical schools developing in Ontario and British Columbia will possibly adopt these streams in future, as their infrastructure matures.

Longer elective blocks enable a full exposure to the lifestyle and career pattern of preceptors living in the community. Curricula typically focus on general psychiatry skills, and community liaison and administration experience may be balanced with direct clinical time. To develop core rotations outside the academic centre, however, there must be great initial investment in finding appropriate preceptors and in meeting accreditation

standards. Importantly, family medicine programs often have an existing infrastructure for travel and accommodation arrangements that can be used by the psychiatry program.

If core rotations are offered on a voluntary basis only, residents may have too little interest to support investment in the necessary administrative structure. Conversely, mandatory rotations have been greatly resisted by residents, especially by those with settled families or a working spouse. In small programs in particular, introducing mandatory rural placement during training may adversely affect the program's ability to attract residents under the Canadian Resident Matching Service. Overall in Canada, only larger programs have been able to begin developing these types of opportunities. Notably, once a few trainees take up these placements, interest often grows by word of mouth within a training program. This may be particularly true when a specific preceptor proves to be a skilled clinician and educator or, in some cases, when the equivalent urban rotations are unpopular.

Many important questions must be resolved to facilitate the success of such initiatives as selecting and paying academic staff who live on-site, ensuring their continuing professional development, monitoring their effectiveness, accrediting training sites and local facilities, and supporting residents, which includes offering accommodation and making provisions for family members. In Canada, the potential may exist to develop 3 or 4 specific sites to train psychiatric residents in rural and remote psychiatry. Smaller training sites may be unable to offer an adequate range of psychiatric specialty training, and for this purpose, it may be necessary to develop ongoing coordination between different university sites.

Education for Recruitment and Retention

While small community settings may be ideal locations for training general psychiatrists, these programs have added benefits for long-range workforce planning. The primary care literature has long asserted the relation between training location and choice of practice location. In addition, the availability of preceptor appointments seems to enhance retention of those physicians already on site.

It has been well documented that efforts to influence the location of physician practice are largely ineffective if they are undertaken too late in training (34). By then, most physicians have become rooted to their place of residence on the basis of their child's schooling, their spouse's employment, or their own social and professional network. To more effectively encourage psychiatrists and other physicians to locate their practices in a greater variety of Canadian locations, distributed learning models that offer early decentralization in training are required.

The US and Australia publish most of the rural and remote medical education literature. A handful of US programs have reported good outcomes for rural psychiatry training streams (21,35,36). However, these may have limited applicability to the Canadian context of large and varied geography and dispersed population.

In Canada, a few programs have reported outcomes for rural and remote postgraduate training experiences. The Northwestern Ontario Medical Programme recently published 25 years of student-tracking data for undergraduates and mainly family medicine residents. Multiple placements throughout training, as well as any postgraduate placements, correlated significantly with choosing practice in northwestern Ontario. Postgraduate rotations in particular correlated with ultimate practice location (37).

Dalhousie University has reported success with a distributed learning model for all family and specialist programs (38), although there is likely a small community-selection bias among residents that choose to train in such a program. Overall, rates were favourable, relative to programs without small-community training sites. The study of graduates between 1981 and 1991 showed that 20% of psychiatry residents chose a rural (that is, population < 10 000) practice location. Interestingly, rural psychiatry recruitment was less successful, compared with other specialties: internal medicine showed a 50% rural recruitment rate; general surgery, otolaryngology, and ophthalmology all showed a 60% rural recruitment rate. This finding raises the question of whether there are more obstacles or fewer incentives for a psychiatrist considering a small community practice location.

The literature from other countries and the experience of other Canadian postgraduate programs suggest that psychiatry programs can apply several strategies. First, increasing the number of psychiatrists serving rural communities will ideally begin with admissions policies that prioritize students from rural areas. Indicators that a trainee intends to set up rural practice should be important factors in the selection of trainees during the postgraduate period (39). Second, efforts to appropriately match students and trainees with communities and to maximize the quality of the educational experience will be required throughout the full period of training. Third, it is essential to emphasize the unique skills necessary for this environment to prepare residents for more independent general practice. Fourth, experience in these settings should be offered early and often.

Summary of Recommendations

1. Unique curricula should be developed for rural and remote educational programs, based on CanMEDS 2000 principles. Urban-based objectives and

curricula should not be “force-fit” to rural and remote learning experiences.

2. Models of service and education (such as shared care) that support collaboration with other health professionals should be emphasized.
3. Specific medical school and residency admissions programs should be put in place to attract students who have lived in or undertaken secondary and undergraduate university education in rural areas.
4. In general, rural and remote experiences should be introduced to residency programs as electives. Trainees often resent mandatory training in these areas. Further, careful consideration should be given to optimizing the match between residents and the communities in which they are placed.
5. Exposure to rural and remote communities should be maximized during medical school and residency. Where possible, longer, on-site rotations should be developed.
6. When shorter experiences (such as “fly-ins”) are used, they should be organized to maximize resident exposure to the community. This could include repeat visits, longer stays, and working with local health professionals.
7. Universities should demonstrate that they value faculty in rural and remote areas. This includes meaningful faculty appointments, opportunities to participate in the university’s education and research activities, invitations to share expertise with the larger urban resident group, and annual review of academic activities.
8. Adequate funding to support the development of rural sites, faculty, and trainees’ travel and accommodation needs will have to be addressed to create successful rural education programs.
9. Relations between urban and rural or remote communities should be bidirectional. Collaboration is preferable to missionary work. “Inreach” should be encouraged as much as outreach.
10. Rural streams in residency programs should offer new and additional opportunities for training residents rather than simply moving training positions from urban locations. This recommendation recognizes the global shortage of Canadian psychiatrists and will help to maintain good relations between AHSCs and new rural or remote training programs.
11. Studies exploring the effectiveness of various models of rural and remote training in psychiatry should be undertaken and form part of the rural academic educational agenda.

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